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February 4, 2019

TO: Supervisor Janice Hahn, Chair
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Supervisor Mark Ridley-Thomas
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FROM: Max Huntsman
Inspector General

SUBJECT: REPORT BACK ON ENSURING SAFETY AND HUMANE TREATMENT IN THE COUNTY'S JUVENILE JUSTICE FACILITIES

Introduction

On December 18, 2018, the Los Angeles County Board of Supervisors (Board) directed the Office of the Inspector General (OIG) to investigate safety concerns in Los Angeles County Probation Department (Department) juvenile halls and camps, with an emphasis on use-of-force incidents involving oleoresin capsicum (OC) spray (also known as pepper spray), and to report back with findings and related recommendations. The Board also instructed the OIG to address de-escalation tools and any staffing issues that impede de-escalation efforts.

The Department maintained an open and collaborative approach throughout the OIG's review. Department staff, managers, and executive leadership were accommodating and transparent, and the Department responded to document and information requests thoroughly and quickly. Department personnel and executives made themselves available for inquiries, meetings, and follow-up at each step of the review. Many of the issues addressed in this review were articulated by Department executives at the outset, and input from Department members contributed to the development of OIG recommendations.

The majority of Department staff who spoke with the OIG expressed a passion for their work and a determination to positively affect the lives of youth. Some also shared challenges and frustrations. Conversations with youth, staff, and managers revealed many shared opinions regarding safety concerns, lack of resources, concerns about policies, training and practices, and the need for improved communication and ongoing dialogue within the Department.

The OIG's review confirms reports by Department executives, staff, and youth that some staff have engaged in inappropriate and avoidable uses of OC spray and have failed to properly decontaminate youth who have been exposed to OC. In those instances where egregious acts were suspected to have been committed, the Department reports that it has removed staff from direct contact with youth and will be taking disciplinary action if appropriate.

In some instances, staff who have not received effective training, including training on de-escalation techniques, may rely on OC spray as a default or as an intermediary step to obtain compliance rather than as a last resort in potentially or actively dangerous situations. In some instances, youth have been ineffectively decontaminated, or decontaminated long after exposure to OC spray.

Lack of adequate training, supervision, accountability systems, and policies, which may be exacerbated by an apparent lack of resources, likely contribute to out-of-policy use of and over-reliance on OC spray. In general, staff reported feeling unsupported and ill equipped to effectively interact with youth, especially those with acute mental health and behavioral needs. Specifically, staff consistently identified a lack of effective policies and training that would prepare them to attempt to de-escalate tense situations and avoid using OC spray.

Background

The Department is composed of approximately 6,000 staff members who work in more than eighty facilities across the county, including three juvenile halls, seven youth camps, and the Dorothy Kirby Center, a secured, residential facility that provides enhanced mental health services for youth. The Department interacts with an average daily population of approximately 7,750 youth in its camps, juvenile halls, and at-home placements, making it the largest probation department in the nation. Throughout 2018, approximately 900 of these youth were housed in its juvenile halls and camps on any given day.

The Department currently authorizes staff to use OC spray in its juvenile halls (Barry J. Nidorf Juvenile Hall, Central Juvenile Hall, and Los Padrinos Juvenile Hall) and two youth camps (Camp Ellison Onizuka and Camp Ronald

McNair, both a part of the Challenger Memorial Youth Center). Thirty-five states have banned the use of OC spray in juvenile facilities and California is one of six states (in addition to Illinois, Texas, South Carolina, Indiana and Minnesota) that allow staff in juvenile facilities to carry OC canisters.[1] The OIG spoke with several representatives from county probation departments throughout California regarding the use of OC spray and de-escalation tactics. San Francisco County, Santa Cruz County, Marin County, and Santa Clara County do not permit the use of OC spray in their juvenile facilities.

Representatives from all four county probation departments shared information regarding non-punitive alternatives to use-of-force that have reportedly served them well and stressed the importance of policies and practices that foster positive relationships between youth and staff. The OIG also spoke to systems that make use of OC spray.

In March of 2018, the Department reported a significant increase in the use of OC spray in its juvenile halls from 2015 through 2017:

- Central Juvenile Hall: 338%
- Los Padrinos Juvenile Hall: 214%
- Barry J. Nidorf: 192%[2]

At the time, the Department had not analyzed OC spray figures in its camps.[3] No changes to the Department's core use-of-force policy took place during that time. The Department also reported an increase in youth-on-youth assaults (66%) and youth assaults on staff (58%) from 2016 through 2017.[4]

In December of 2018, the Department cited a 20% decrease in the use of OC spray in juvenile halls and camps, when compared to 2017.[5] The Department reports that it is conducting on going internal review of OC related incidents and has generated additional data. The OIG has recommended and the Department has agreed to increase transparency by developing a plan to regularly publish use-of-force and violence data on the Department website.

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[1] Report by Legislative Counsel David Billingsley presented to the Assembly Committee on Public Safety for hearing held April 17, 2018, pg. 4; *see also* Council of Juvenile Correctional Administrators, Issue Brief: Pepper Spray in Youth Facilities (May 2011), p.2, *available at* http://cjca.net/wp-content/uploads/2018/02/CJCA.Issue_.Brief_.OCSpray.pdf (last accessed January 30, 2019).
[2] County of Los Angeles Probation Commission, Minutes of Regular Meeting of March 22, 2018, *available at* http://file.lacounty.gov/SDSInter/probation/1039083_ProbationCommissionMinutes03-22-2018.pdf (last accessed January 22, 2019).
[3] *Ibid.*
[4] *Id.*
[5] County of Los Angeles Board of Supervisors, December 18, 2018 Meeting Transcript, pg. 133, *available at* http://file.lacounty.gov/SDSInter/bos/sop/transcripts/1048857_121818.pdf (last accessed January 22, 2019).

The Department's Safe Crisis Management (SCM) policy currently governs the use-of-force (including use of OC spray) and its review in County juvenile justice facilities. The SCM policy addresses varied topics that include staff training requirements, reporting protocols, and the use of physical restraints and OC spray.[6] The SCM policy organizes force on a continuum, with six total levels that progress from less to more significant physical and chemical interventions (i.e. OC spray). It requires that force only be used as "necessary and appropriate to restore order and/or achieve and maintain control" and not as a form of "discipline, punishment or retaliation."[7] It also details a host of de-escalation approaches and prohibits certain kinds of force techniques, including the carotid restraint (commonly referred to as a "chokehold").[8]

OC spray is the most significant force option authorized by the Department, with the SCM policy describing it as "the final and ultimate authorized" method to "gain control of a situation and/or subdue" youth.[9] During "controlled situations," which the SCM policy generally defines as situations in which youth are not actively physically aggressive, OC spray may only be used at the discretion of a supervisor.[10] In "uncontrolled situations," which are defined as incidents during which staff must respond immediately, officers are authorized to rely on OC spray without supervisory approval.[11] The Department prohibits the use of OC spray on individuals who are receiving psychotropic medications, under the influence of stimulants, suffer from asthma or other respiratory issues, have a history of heart disease or seizures, are pregnant, or are clinically obese.[12]

The Department's senior leadership provided the OIG with information regarding its assessments of several force-related issues. In August of 2017, the Department prepared a report for the Board of Supervisors outlining targeted strategic initiatives for establishing greater accountability, rehabilitating youth, maintaining a core workforce of professionals by promoting development and wellness, and strengthening communities.

The Department identifies several key issues that echo concerns communicated to the OIG during conversations with leadership, staff, and youth. These issues, several of which are outlined below, include improving training infrastructure, creating a robust auditing function, and implementing systemic reform in the internal affairs processes and the grievance system, among other efforts.

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[6] Probation Department Safe Crisis Management Policy Directive (SCM Directive), pg. 1.
[7] *Ibid.*
[8] *Id.* at 4.
[9] *Id.* at 23.
[10] *Id.* at 8.
[11] *Id.* at 33.
[12] *Id.* at 25-26.

The Department reports that it has also conducted an in-depth self-assessment of its accountability systems and related resource needs. The self-assessment included a review of recent problematic use-of-force incidents. As a result, the Department developed a detailed strategy to eliminate unnecessary or excessive uses of force in its facilities. The Department's self-assessments indicate an institutional awareness and willingness to identify and implement corrective measures. These fundamental qualities are critical to bringing about positive and sustainable change through systemic reform and demonstrate the Department's commitment to providing youth and staff with a safe environment.

Methods

OIG staff reviewed Department policies, training materials, and information related to particular uses of force and the reviews that followed. OIG staff reviewed existing assessments and evaluations, from internal and external sources, of Department organization, administration, and operations.

OIG staff visited every juvenile justice facility where the use of OC spray is authorized, and spoke with more than forty-five incarcerated youth representing each of the County's juvenile halls, Camp Ellison Onizuka, and Camp Ronald McNair. In order to ensure that applicable rights and privileges were safeguarded, representatives of the Public Defender, Alternate Public Defender, and the Los Angeles County Bar Association's Independent Juvenile Defender Program were present during conversations with youth. OIG staff also spoke with more than thirty line-level Department staff and managers at facilities visited, Department executive leadership including the Chief Probation Officer, facility mental health providers, and union representatives.

In addition, OIG staff reviewed twenty-one incidents that were identified through a Department audit of use-of-force reports and reviewed videos generated from October 2017 through November 2018 in the juvenile halls and camps. The Department initiated the audit following a series of troubling use-of-force incidents. The OIG reviewed available information, including reports, closed-circuit television (CCTV) footage of the incidents, and reviews that followed. The OIG did *not* conduct an independent audit of a representative sample of all reported uses of force for a given time period, nor did the OIG review the OC cases that the Department audit revealed were within policy. The below analysis follows a qualitative review of a specific set of Department identified incidents.

Regarding information provided by youth and staff, the OIG has neither verified nor independently investigated allegations detailed in this report. To

ensure confidentiality and safety, the OIG agreed not to document any identifying information unless a youth threatened harm to self or others.

Use-of-force Incidents and Safety Concerns

The OIG's onsite visits, conversations with staff and youth, and review of force incidents reveal several problematic practices. The problematic incidents identified by the department and reviewed by the OIG include several examples of OC spray applications and multiple instances of improper or ineffective decontamination practices that likely violate Department policy.[13]

Staff and youth interviewed detailed concerns with OC spray use, and with staff who may not be adequately prepared to prevent uses of force. Staff and youth recognized that strong relationships and healthy communication are crucial to creating a safe environment. Youth praised staff who treated them with respect and took the time to build constructive rapport. However, youth also reported that some staff were overly harsh or retaliatory, creating a culture based on punishment and force rather than rehabilitation and support. Safety concerns identified by staff and youth are discussed in more detail below.

OC Spray

Based on incidents reviewed and youth and staff reporting, OC spray appears to be a commonly used tool by some staff to obtain compliance; however, it is not always justified or used as the final and most significant force option consistent with Department policy. The twenty-one force incidents reviewed suggest a consistent use of OC spray as an initial or intermediary force option, rather than as one that follows a failure to de-escalate or the use of less significant force. Several of the incidents also involve the use of OC spray where there did not appear to be actual or potential threat of harm by youth. Some staff also acknowledged the common use of OC spray, and one line-level supervisor plainly stated that some staff were engaging in "justified overreliance" on OC spray.

Some incidents reviewed include uses of OC spray that likely violate Department policies, at times involving youth who appeared only passively non-compliant. In several incidents, the use-of-force reports filed by staff described youth behaviors as aggressive or threatening, even when available video footage showed that youth appeared to pose no threat to staff.

Other incidents involved staff who used OC spray before any attempts to use other, less significant force techniques. Similarly, several incidents involve

[13] Most incidents reviewed are currently being investigated and final determinations about policy violations or criminal conduct are pending.

situations in which de-escalation strategies, including the involvement of mental health professionals, may have been fruitful but where not attempted.

Several youth reported that some staff threaten the use of OC spray or retrieve and shake OC canisters in front of youth as the initial and sole effort to gain compliance without first giving verbal commands. Youth reports are consistent with video footage reviewed. While threatening the use of OC spray may achieve compliance in some situations, it appears to have unnecessarily escalated confrontations in others.

In some incidents reviewed, OC spray was used on youth who, under the Department's SCM policy, should not have been subject to OC spray unless all other alternatives to gain compliance had first been exhausted. The OIG reviewed incidents in which youth with identified respiratory conditions and youth taking psychotropic medications were subjects of OC spray.

In one incident reviewed, a youth with a mental health condition was engaging in self-harming behavior, and was OC sprayed in the groin and buttocks. Following the use of OC spray, the youth was left in a room, which apparently lacked running water, for approximately 20 minutes before being decontaminated. In violation of the SCM policy, staff did not make reasonable attempts at physical intervention before relying on OC spray during these incidents. Furthermore, the use-of-force reports that arose from this incident were found to be incomplete, failing to accurately describe the events that led to the use-of-force and OC deployment. The Department reports that the involved employee was subsequently terminated.

OC Spray Warnings

The Department's SCM policy, which is in the process of being revised, contains conflicting and inconsistent requirements for OC spray warnings that staff are required to provide to youth before deploying OC spray. Some youth detailed issues with OC spray warnings by staff, citing instances in which they did and did not receive warnings before OC spray was deployed.

Some youth also expressed confusion over what constitutes a proper warning, stating that some staff relied on variations of "OC Warning," while others only instructed youth to get down on the floor or stop their behavior. One youth, who was recently the subject of OC use, stated the youth would have complied with an order if one had been issued.

Other youth stated that certain staff issue blanket warnings when they begin their shift or arrive on a unit, even if there are no incidents at that point that would justify a warning or the use-of-force. Some youth reported that blanket or

preemptive warnings made them uneasy, and they are unable to predict which specific conduct might result in OC spray.

Inadvertent Exposure to OC Spray

OIG staff received reports of Department personnel inadvertently exposing youth to OC spray. Several youth recounted being exposed to OC spray when staff were engaging with other youth, or when staff used OC spray while chasing youth. One youth spoke about being OC sprayed on the back, and another stated a significant amount of OC spray hit the youth's mouth. Both youth stated that, following the incident, staff indicated that the OC deployments were accidental.

Some incidents identified by the Department and reviewed by the OIG also involve unintended OC exposure of bystanders stemming from altercations between staff and a youth. Reports and available footage suggest that following the confrontations, staff members appeared to deploy OC despite the fact that the youth did not appear to pose an imminent physical threat to staff or surrounding youth.

OC Spray Decontamination

Youth described consistently negative experiences with decontamination in the juvenile halls and camps. The most common complaints from youth were related to delayed decontamination and the use of hot water to decontaminate youth. Several youth, at several facilities, reported being exposed to OC and then placed in their rooms for upwards of thirty minutes before any attempts to decontaminate were made.

One youth reported hearing others suffering in their rooms on several occasions following the application of OC spray. Several youth reported staff-led decontamination efforts that involved hot water or towels, two improper decontamination practices that may increase the discomfort that follows OC spray. Youth stated that staff often make use of shower facilities for decontamination, and that staff and youth often lack the ability to control the temperature of most showers. Others detailed being confined to their rooms for extended periods of time after an OC spray, and receiving only a wet towel to assist with decontamination. These practices, if true, would violate the Department's SCM policy.

Some use-of-force incidents identified by the Department as problematic indicate failures to timely and effectively decontaminate youth after OC spray exposure. Among incidents reviewed, staff appear to repeatedly place recently sprayed, un-decontaminated youth in their rooms. In several incidents, youth

appear to have been left in their rooms, visibly struggling, for periods exceeding fifteen to thirty minutes, without apparent efforts to decontaminate them.

In some instances, youth were exposed to OC spray and placed in rooms with toilet and sink units. The sink water was either not functioning or was turned off, and youth can be seen attempting to self-decontaminate from the toilet.

Staffing Issues

Some Department staff expressed having low morale. As described in detail below, reported morale issues may be exacerbated by a perceived lack of sufficient staffing and a lack of trust in existing accountability structures.

Staffing and Supervision Resources

Staff interviewed frequently expressed fear regarding their personal safety and consistently reported feeling outnumbered and overpowered by youth in juvenile halls and camps. Several staff cited inconsistent and inadequate staffing as a chief source of unease. Department managers and executives cited difficulties in recruitment and retention of staff and various labor-related issues as contributing to difficulties in maintaining ideal staffing ratios throughout its facilities.

Line-level staff expressed frustration with sometimes having to perform their duties without supervision. According to some staff, the lack of supervisors may be hindering the proper use of OC spray and force, since supervisors are required to authorize and direct force in certain situations. Some staff also believe that the strains that come with the lack of supervisory support and guidance contribute to low morale and performance. The Department reports that it has added some supervisors, but anticipates additional needs.

Insufficient staffing of supervisors may also negatively impact the Department's ability to adequately review uses of force. For example, several of the incidents reviewed were initially assessed by Department supervisors who failed to identify potential policy violations and refer the incidents for further review, despite indicators that force was inappropriate or excessive.

The Department reports that it has been working to standardize facility staffing, but that sick leave and long-term absences de-stablize the Department's workforce. The Department reports that it is working with the County Department of Human Resources to pilot new strategies for countywide leave practices that may reduce long-term absences and facility shortages, including permanent placement, medical retirements and other accommodation matters.

Accountability

Overreliance on and out-of-policy OC use may also be driven by a belief frequently communicated by staff during conversations with the OIG: physical uses of force are more likely to lead to injuries and result in internal affairs investigations. While policies identify OC spray as the final and most significant force option, several staff reported fear of physical injury as a driving reason for using OC in lieu of hands-on intervention. Some staff also stated that recent investigations and disciplinary actions by the Department led them to conclude that OC deployments invite less scrutiny than physical force.

Various staff and union representatives further expressed a lack of trust in the Department's accountability protocols. Staff interviewed routinely communicated a belief that internal affairs is poorly staffed and trained. They cited the length and quality of investigations as a serious concern, and a general perception that the results of investigations suffer because of it.

Training

Several staff reported feeling inadequately trained to effectively respond to crisis situations in a manner that may minimize the need to use force. In particular, staff reported a lack of training in de-escalation and physical intervention techniques. One recently hired probation officer expressed disappointment with the Department's new-hire training, stating that courses involving physical force techniques were insufficient and unrealistic. Staff recognized that de-escalation and physical intervention techniques are "perishable skills" that require regular and frequent training to master. As a result, staff expressed a strong desire for additional scenario-based training.

Some officers also articulated various kinds of unease or confusion in determining when and/or how to use force. Several cited a sense of crisis following the elimination of special housing units in County facilities, stating that the inability to place youth in a solitary confinement setting made dealing with problem behaviors difficult. They believed that workable alternatives were not provided, leaving staff scrambling for other ways to address problem youth behaviors.

The Department reports that due to significant increases in the use of OC spray, it is implementing multiple short and long term training initiatives, including: (1) trauma informed training, provided by the Center for the Empowerment of Families, (2) Non-Violent Crisis Intervention de-escalation training by the Crisis Prevention Institute, and (3) a training and technical assistance program, Youth in Custody Practice Model, by the Council of Juvenile Correctional Administrators and the Center for Juvenile Justice Reform at

Georgetown University's McCourt School of Public Policy. Lastly, the Department reports that it completed an internal analysis and identified that 36% of staff in the juvenile halls were responsible for most OC use and that, as of February 1, 2019, 56% of all full duty personnel in the halls, have received the refresher OC spray training.[14]

Mental Health Resources

Department staff generally reported being unprepared to deal with youth experiencing behavioral and mental health issues, which form an increasing percentage of the County's youth population. Several staff stated that the youth populations housed in the County's juvenile halls and camps suffer from more serious mental health conditions than previous groups, and that training and policies have not kept pace. Both Department and mental health staff also reported that facilities lack adequate mental health resources. Department staff reported that inadequate mental health staffing hinders de-escalation efforts. Deficiencies were reportedly more problematic on evenings, weekends, and holidays.

One mental health professional working at a juvenile hall stated that it was difficult to work effectively with probation staff because of concerns about lack of both mental health and Department staff. According to that individual, mental health supervisors have discouraged providers from placing youth in crisis on one-on-one supervision because it strains Department staffing resources.

Culture

Youth and staff consistently spoke with one voice on a particular topic: the importance of relationships, interpersonal communication, and mutual respect in improving safety and preventing force. Several staff reported never having to rely on physical intervention or OC spray when dealing with youth, citing their "verbal judo" or "gift of gab" as attributes that allowed them to address problem behaviors and minimize the need to rely on force. Those staff members also consistently stated that they felt the Department's training did not provide them with effective use-of-force alternatives.

Youth similarly praised staff who, in their perspective, are respectful and willing to get to know youth. Various youth described staff members who go to great lengths to build rapport with them, and who avoid using OC spray and other force in interacting with them. However, several youth related stories of frequent disrespect and verbal mistreatment by staff, which some cited as creating tense

[14] The OIG has not verified the information provided by the Department regarding measures it has taken to improve training.

situations that might lead to aggressive behavior. Some youth reported receiving or hearing profanity-laden taunts from staff, including criticisms of their neighborhoods, their families, and, in some instances, threats. Youth at two different facilities stated that staff told them that if they did not behave, they would "join their dead homies."

Youth also reported some potentially retaliatory actions that they cited as creating an environment in which conflict between staff and youth is more likely to escalate into situations that require force. Chief among these were examples of denying access to programs. One youth stated that the youth had been denied the opportunity to attend church services, which were described as a "privilege" that the youth had failed to earn. OIG staff reviewed an OC spray incident that reportedly arose from similar facts. Lastly, some youth stated that they were occasionally subjected to group discipline, confined to their rooms for extended periods of time, and denied access to programing. If accurate and common, these incidents raise significant concerns regarding the legal rights of youth, collective punishment, and general conditions in County facilities.

Finally, some youth reported being denied timely access to toilets and having to rely on trash or other containers in their rooms to relieve themselves. These allegations raise issues about facility infrastructure (including the prevalence of rooms without toilets) and staffing resources (staff must escort youth in toilet-less rooms to appropriate facilities), which may result in the neglect of youths' basic human needs.

Some incidents reviewed involve clear misconduct. While some inappropriate conduct identified might be prevented through effective policy revision and training, the most problematic incidents detailed above are symptoms larger systemic and cultural issues that require immediate and extensive analysis and reform.

Policies, Practices, and Training Issues

The safety concerns and problematic uses of force described above are likely exacerbated by insufficient use-of-force policies, training, reporting, and accountability practices. Effective use-of-force policies and training provide a framework for officers to understand precisely how and when force can be used and how it might be avoided. They do so by identifying applicable laws, standards and limits, and by delineating the factors that should be considered before and after employing force. By providing clear requirements, use-of-force policies safeguard the well-being of both staff and youth by limiting force to situations in which it is necessary.

While comprehensive use-of-force policies are essential, their efficacy is wholly dependent on thorough, effective, and frequent training. Use-of-force training should aim to provide staff with the required knowledge, skills, and judgment to execute their duties and responsibilities in a safe and effective manner. Effective training should also utilize evidence-based techniques to minimize use-of-force incidents with a focus as much on scenario-based force prevention and de-escalation exercises.

Use-of-force and De-escalation Policies

The current SCM policy is hampered by a host of issues that likely contribute to avoidable OC spray incidents. As described above, the SCM policy is currently structured along a continuum. Use-of-force continuums can often lead law enforcement staff to automatically move through increasingly more severe force options when less severe options have proved ineffective. The Department's draft use-of-force policy reflects an understanding of this, and does away with the continuum. The Department reports that the draft policy is under review by labor unions and has committed to additional revisions based on OIG recommendations detailed below.

The SCM policy does not currently provide workable definitions of threshold terms that govern whether or not OC spray is authorized. For example, the SCM policy authorizes staff to use OC spray without supervisory authority during "uncontrolled situations," which are described as incidents in which "a major disturbance, fight, assault or escape attempt…occurs quickly, requiring staff to respond immediately and employ more restrictive alternatives on an escalating basis…"[15] Other sections of the SCM policy also state that OC spray is authorized for "serious disturbances" or "major facility disturbances."[16] The SCM policy does not provide a definition of "a major disturbance," requiring staff to use their discretion to identify such instances.

The Department's current SCM policy and draft use-of-force policy also include inconsistent requirements for OC spray warnings, which may frustrate their usefulness as de-escalation and force prevention tools. Department staff often cited the warnings as a tool to gain compliance from recalcitrant youth. Unfortunately, the required warning varies depending on the section of the SCM policy:

- Page 12: "Staff shall provide a warning to minors involved in the incident regarding the intended use of chemical intervention by clearly stating in a loud voice, 'O.C. warning!'"

[15] SCM Directive at 33.
[16] *Id.* at 4 and 26.

- Page 25: The Department "shall advise minors that…if staff instruct them to get down, take a knee, or use the words 'OC spray' they are to [comply] immediately" or they may be sprayed.
- Page 32: "[S]taff shall provide a warning regarding the intended use of chemical intervention by clearly stating in a loud, commanding voice: 'O.C. spray.'"

Based on conversations with youth, these inconsistent warnings have at times denied youth an opportunity to comply with staff instructions before being OC sprayed. The inconsistencies may also make it difficult to hold staff accountable when they fail to deliver appropriate warnings.

The Department is in the process of revising its SCM policy and other policies that will govern its use-of-force reviews. The draft use-of-force policy introduces several positive changes to the way officers are required to think about and use force. The draft moves away from the use of a rigid force continuum and structures all uses of force on the well-established "objectively reasonable" standard articulated by the United States Supreme Court. The draft use-of-force policy explains that reasonable force is "the force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to gain compliance."[17] The draft use-of-force policy provides a non-exhaustive list of factors used to evaluate whether the use-of-force is objectively reasonable, including: "the nature and severity of the situation; whether the youth poses an immediate threat to the safety of the staff and/or others; and, whether the youth is actively resisting."[18]

In addition, the draft use-of-force policy delineates boundaries for how and when force may be objectively reasonable. First, the draft use-of-force policy eliminates the distinction between controlled and uncontrolled situations that currently governs whether the use-of-force is authorized for a given situation and draws a similar distinction between "directed use-of-force incidents" for "non-emergent situations" that require the presence of a supervisor to plan and direct the use-of-force, and "immediate use-of-force incidents" for situations that threaten the "safety and security of youth, staff and/or the public."[19] However, unlike the SCM policy, the draft use-of-force policy does not dictate a defined list of situations that fall within each category. Instead, it provides examples of situations that may fall within each category and ultimately predicates the authorized use of reasonable force on the facts of the situation at hand.

[17] Draft Use-of-force Policy, pg. 3
[18] *Ibid.*
[19] *Ibid.*

Next, the draft use-of-force policy provides that "[s]taff shall only utilize force as a last resort and shall only use that level of force which is objectively reasonable."[20] The draft use-of-force policy requires that staff utilize, where reasonably possible, de-escalation strategies when faced with a crisis situation and outlines an extensive list of de-escalation strategies. However, the draft use-of-force policy acknowledges that if staff "reasonably determine that de-escalation techniques are ineffective or cannot be utilized due to imminent danger," "the use of immediate physical or chemical intervention may be required."[21] If a use-of-force is necessary, the draft use-of-force policy prescribes a "dignity-based approach" requiring that all youth "continually be treated with dignity and respect" during the incident.[22] The "dignity-based approach" reflects the Department's commitment to an overall philosophy of preventing and limiting force.

Training

The Department's use-of-force training curriculum aims to provide staff with a broad range of knowledge and skills, including development and behavior theories, effective communication, self-management, misbehavior prevention strategies, de-escalation strategies, physical and chemical interventions, and report writing. All incoming staff assigned to juvenile facilities are required to participate in twenty-four hours of use-of-force training as part of their Juvenile Corrections Officer Core Training. In addition, the Department mandates sixteen hours of use-of-force retraining annually. The substantial increase in the use of OC spray generally, use-of-force incidents reviewed by the OIG, and reporting by staff and youth underscore the need to assess, revise, and bolster current training programs.

In reviewing use-of-force training material provided by the Department, the OIG noted a problematic slide that was included in both the new hire and annual training presentations. The slide, titled "DID YOU REALLY MEAN WHAT YOU WROTE?" displays an animated graphic of a masked criminal behind a red prohibitory sign.[23] The slide purports that certain terms should not be used when writing a use-of-force incident report because the terms may "unintentionally evoke suspicion."[24] The slide provides several examples of terms that should be avoided, including tackled, threw, dragged, twisted hands/arms, bent arms back, and pinned. Lastly, the slide explains that if a term is "unavoidable," staff should "fully describe the circumstances" and "justify" their actions.[25]

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[20] *Ibid.*
[21] *Id.* at 8-9.
[22] *Id.* at 3.
[23] SCM Staff Training Presentation Slide 132, see Figure 1 (emphasis in original).
[24] *Id.*
[25] *Ibid.*

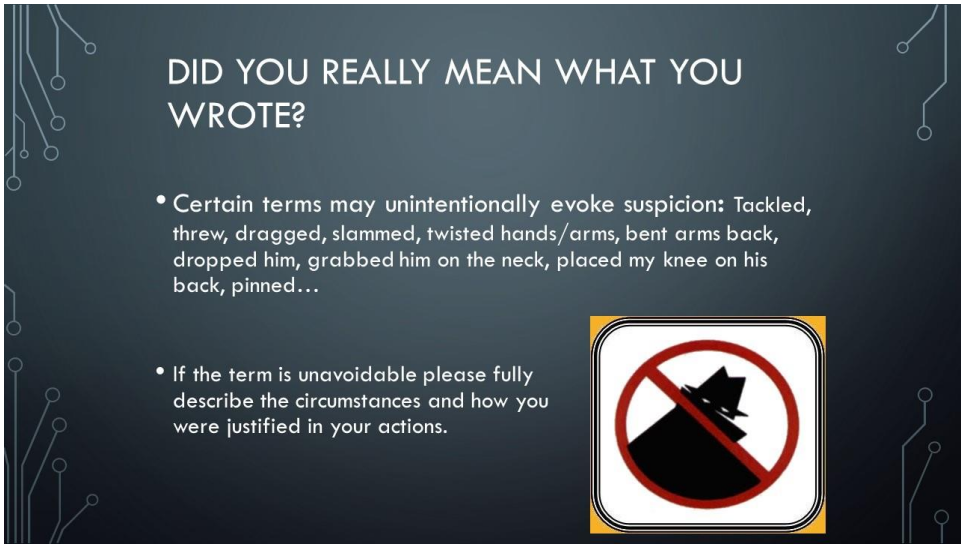

Fig. 1

A problematic example of a term the slide suggests staff avoid is "slammed." The Department's current use-of-force policy explicitly prohibits slamming youth.[26] Staff may interpret the slide to suggest that, if they believe a youth was slammed, they should use less-descriptive language to recount the incident in the use-of-force report. Trainees should be encouraged to avoid specific tactics where possible, but not to avoid accurate language in describing tactics used.

Use-of-force Reporting, Review, and Accountability Practices

The review of use-of-force incidents allows law enforcement agencies to test not only whether individual officers complied with policies and training, but also whether policies and training are sufficiently tailored to the needs of staff and youth. A comprehensive use-of-force review regimen rests on accurate and timely reporting by staff. Such reports and other available information, including video, are then reviewed to ensure accuracy, policy compliance, and the efficacy of policies and training. The incidents reviewed suggest serious deficiencies in the Department's current reporting and review procedures. The Department is currently revising its force review policies, and is working toward creating a standardized use-of-force review process that will seek to identify draft policy and training failures so that they can be addressed in a timely fashion. The Department's draft force review policy includes various improvements to its processes.

[26] SCM Directive at 4.

Use-of-force Reporting

Complete, accurate, and truthful reporting maintain the integrity and reliability of the Department's use-of-force reporting process. According to the SCM policy, staff who participated in a physical or chemical intervention are required to complete a Physical Intervention Report (PIR). In addition, staff who witness the incident, or who were assigned to the unit at the time the incident occurred, are required to complete a Supplemental Physical Intervention Report (SUP-PIR).

A majority of the staff-generated reports associated with the troubling incidents reviewed were not comprehensive and appeared to omit necessary information. Reports rarely described the events that led to the use-of-force, making it difficult for subsequent reviewers to assess the need for the force used. Additionally, several reports did not appear to accurately describe the youth behavior that necessitated the use of OC spray, stating generally that the subject youth moved aggressively in attempts to assault staff, though video shows a passive posture and no movement.

Use-of-force Review and Accountability Practices

The SCM policy details the Department's use-of-force report and review process. Staff members who are involved in or observed a use-of-force are required to prepare PIRs no later than the end of the eight-hour shift during which the incident occurred.[27] Reports must be clear and comprehensive, and staff must memorialize a host of factors, including: de-escalation attempts, the factors that gave rise to the need to use force, and the type of force used. Staff must also record a "full description of O.C. spray post-deployment decontamination."[28] The SCM policy does not require staff to photograph injuries of youth who are subjects of force.

Once submitted, PIRs and related documents are reviewed by the presiding shift leader and duty supervisor for completeness and accuracy.[29] If they are found lacking, they are returned to the relevant staff for necessary amendments. They are then passed on to the particular facility's SCM Supervising Coordinator, who reviews the documentation and conducts interviews with involved youth and witnesses.[30] If the underlying force incident appears to violate policy, it is then forwarded either to "the facility Director, facility Superintendent, or the Probation Department's Special Investigations Unit."[31]

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[27] *Id.* at 13.
[28] *Id.* at 14.
[29] *Id.* at 15.
[30] *Id.* at 17.
[31] *Ibid.*

The SCM Supervising Coordinator is not explicitly required to view relevant videos of the incident.

The Department's draft force review policy addresses some of these significant issues. It calls for force reviewers to view available videos and assess the accuracy of any written reports. It also requires that a youth reporting injuries be photographed to ensure such necessary evidence is preserved. Significantly, it calls for the creation of Use-of-force Data Coordinators at each Department facility. The Data Coordinators will be tasked with ensuring that relevant force data is collected for input into the Department's various databases.

According to information provided by the Department and information gathered during site visits, Department facilities lack the necessary technology infrastructure to ensure that use-of-force incidents are captured on video. Staff further reported that when videos of force incidents exist, they are difficult to access and view. The Department is aware of this issue and is working to address it.

Department policy also provides for notifying executive Department leadership of certain force incidents that involve potentially problematic use-of-force or protocol violations or failures. The Department's Preliminary Incident Notification (PIN) directive requires that supervising line staff alert their superiors of incidents that involve various factors, including when: (1) there is "any major disturbance at the facility"; (2) an incident "may generate media interest or come to the attention of the Board of Supervisors"; and, (3) "it is likely that the Chief Probation Officer may be contacted."[32] The policy does not include a definition of what constitutes a "major disturbance," and does not provide other specific information or examples about what kinds of incidents fall into the prescribed categories.

In October of 2018, the Department implemented a Critical Incident Review (CIR) protocol that creates a routine assessment of particular incidents to "determine the effectiveness of existing policies and procedures before and after an event, to address the root causes of an event, and to prevent the incident from reoccurring."[33] Policies prescribe that reviews take place twice a month, and involve various Department managers and County counsel.[34] The CIR process is triggered, generally, by an escape, a disturbance involving ten or more people, a suicide or suicide attempt, death of an in-custody youth, and at the discretion of the Chief Probation Officer. It can also be initiated by incidents or situations in which it is likely the Chief Probation Officer may be contacted.

[32] Preliminary Incident Notification Directive, at 1.
[33] Critical Incident Review Process Directive (CIR Directive), at 1.
[34] *Id.* at 4.

An effective use-of-force review process rests, in part, on developed accountability and disciplinary infrastructure. Once spotted, actions that violate use-of-force-related policies should be dealt with in a timely, effective, and consistent manner. The OIG's review of Department-provided information suggests that Internal Affairs is understaffed and overburdened by a high caseload, leading to extensive delays in investigations and resolutions. Drawn out investigations by overworked staff may be a reason staff consistently expressed a distrust and dissatisfaction with Department accountability systems.

OIG discussions suggest that the Department should continue auditing and reviewing its force reporting practices. For example, line-level supervisors and more senior managers reported knowing of the PIN directive — but also had significantly different understandings of what types of incidents merit reporting. Furthermore, the incidents reviewed for this assessment routinely contained staff reports that failed to capture all relevant action, including particular uses of force by staff and descriptive details of decontamination procedures.

Several staff stated that it was difficult to view video because it is not readily accessible. Others reported losing access to the video database during 2017 and 2018. No staff assigned to work at a juvenile hall or camp reported viewing video from other juvenile facilities.

Recommendations

Los Angeles County should evaluate whether the use of OC spray in Department facilities aligns with the Department's philosophical shift toward rehabilitation and trauma informed care and its ongoing implementation of the LA Model. Department personnel and leadership express an awareness of OC spray's physical and emotional harm to youth and of its negative implications for staff-youth relationships and larger Department culture. Most also express, however, a firm belief that absent adequate alternatives, the use of OC spray is necessary to safeguard their personal safety.

Any plan to restrict or eliminate OC spray should prioritize institutional safety, with meticulous attention to youth and staff perceptions about their personal safety, and dedication of necessary resources. Any changes to the use of OC spray in juvenile halls and camps should be incremental and balance training and programmatic needs. The County should explore the feasibility, with significant input from all stakeholders, of restricting or eliminating the use of OC spray in Department juvenile facilities.

Based on the OIG review of existing safety concerns and examination of existing and proposed reporting and accountability practices, training and policies, the OIG makes the recommendations detailed below. While the

recommendations offered generally reference current policies, they have been tailored to ensure that they are relevant to the policy changes currently being considered by the Department.

Accountability and Reporting

Recommendation 1: *The Department should dedicate appropriate resources to finalize and implement its comprehensive use-of-force accountability improvements including its Force Intervention Response Support Team (FIRST) and Department Force Review Committee (DFRC) processes.*

In addition to the Department's existing CIR process, the Department is in the planning stages of a comprehensive force review process. This process includes a team of highly trained personnel who will be required to respond to use-of-force incidents and assist with real-time mentorship and evaluation of de-escalation efforts, tactics, reporting, among other tasks. The team is then responsible for referral of incidents for review by the CIR or what the draft use-of-force policy refers to as the Department Force Review Committee (DFRC). The FIRST should consist of proven effective leaders who possess operational and tactical expertise and who demonstrate an unyielding commitment to the rehabilitative approach. FIRST team members should be single assignment positions.

Every use-of-force incident reviewed should include review of available CCTV footage and should be evaluated for (1) force prevention opportunities, (2) de-escalation efforts, (3) pre-force conduct and tactics, (4) force tactics, (5) post-force incident tactics, (6) decontamination, (7) trauma informed critical incident counseling for and placement of youth as necessary, and (8) post-incident reporting.

The Department's draft use-of-force policy calls on the DFRC to review a selection of use-of-force incidents. The DFRC should analyze *every* OC deployment and the decontamination process following each incident. In assessing the use of OC spray, the DFRC should also evaluate whether staff exercised appropriate judgment and decontaminated youth as soon as possible following the incident. Where decontamination was delayed allegedly due to physical plant, staffing, or other systemic deficiencies, the DRFC should review, identify, and report deficiencies to Department executive leadership, who should take necessary remedial action and implement sustainable solutions as soon as possible.

As necessary, the DFRC should also be empowered to require retraining of particular officers, and it should be tasked with tracking completion of all corrective action. Furthermore, force reviewers at all levels should identify staff

who have effectively prevented the use-of-force and de-escalated tense situations. The Department should recognize and reward these individuals and successes should be shared with all relevant Department personnel.

Recommendation 2: *The Department should dedicate necessary resources and training to effectively implement its Internal Affairs processes.*

The implementation of an effective force review process as described above is time and resource intensive. The Department provided information that strongly suggests that its Internal Affairs team is understaffed and overburdened. Department leadership should continue to work to identify and address unmet staffing needs, and should also continue working to procure necessary tools and training to aid its Internal Affairs staff.

Recommendation 3: *PIN and CIR Directives should more clearly guide staff in determining when to notify leadership of relevant force incidents.*

The PIN Directive serves the important function of creating a conduit for information to travel expeditiously from a juvenile hall or camp to the Department's senior leadership. As described above, the PIN Directive does not currently provide staff with sufficient clarity as to when such notices are required. Without a PIN, Department leadership may not be able to notify the Board of particular incidents.

The Department should revise the PIN Directive so that it provides definitions and instructive examples of factors that trigger a notice. Subjective analysis and judgement on such matters can vary wildly, evidenced in the lack of notices for the 2017 and 2018 incidents audited by the Department and reviewed here. The Department should establish bright line triggers for notice and review to ensure that policy, training, and supervision failures are identified in a timely fashion, and that the Chief Probation Officer and the Board are aware of them. The policy should also be amended to require notification to the DFRC and the CIR committee.

Recommendation 4: *The Department should introduce cameras in all of its juvenile justice facilities. It should also consider updating its CIR policy to require supervisors to view relevant videos of incidents.*

The Department currently lacks sufficient information technology infrastructure to ensure that all use-of-force incidents are captured on CCTV. It should continue to work to address this weakness, and improve access to existing videos by relevant supervisors and force reviewers. Department staff who have been involved in the force incidents should continue filing any necessary reports before viewing relevant videos.

In instances when videos are available, the Department's CIR Directive should require that CIR reports and presentations include them. Staff-generated use-of-force reports are a necessary and effective source of information — but videos can potentially provide reviewers with a new vantage point that might bring relevant information to light. Videos may also serve to help assess the efficacy of particular policies or practices.

Training

Recommendation 5: *The Department should address staff concerns regarding inadequate use-of-force training by developing comprehensive and fully integrated training curriculums and presentations that offer effective alternatives.*

Force prevention, de-escalation, and physical and chemical intervention techniques are important tools that safeguard against unnecessary uses of force. Poorly trained staff lack the ability to de-escalate situations, which likely contributes to avoidable OC spray incidents. Thus, the Department should assess staff concerns regarding insufficient training.

The Department should aim to develop comprehensive and fully integrated use-of-force training and retraining curriculums to ensure that staff have a complete understanding of all related policies and procedures. The presentations should also include slides pertaining to the zero tolerance policy for abuse and slides that encourage staff to report abuse and misconduct by other staff.

Training should also address troubling staff conduct. Several use-of-force incidents reviewed by the OIG involved a failure to timely decontaminate youth following the application of OC spray. Yet, the use-of-force training presentations reviewed lack discussion of decontamination. The Department should develop training that clearly details decontamination procedures and any prohibited practices, such as providing youth with hot or warm water for decontamination purposes. Furthermore, training should clearly articulate circumstances in which shaking a canister in the presence of youth is appropriate and when shaking should be prohibited, with or without deployment.

Recommendation 6: *The Department should assess and enhance training, including off-post training, in interacting with youth with mental health and behavioral needs, and youth in acute mental health crises.*

Several staff reported feeling inadequately trained to care for youth with mental health and behavioral needs. In addition, staff expressed a desire to learn specialized de-escalation techniques for use-of-force incidents involving youth

with mental health needs. The Department should collaborate with the Department of Mental Health (DMH) and, as necessary, mental health juvenile correctional consultants to assess training deficiencies and to provide staff with the tools they need to effectively care for the County's most vulnerable youth population.

Recommendation 7: *The Department should ensure that staff are effectively trained to accurately document all events that led up to the use-of-force, including staff and youth behaviors that precipitated force, and decontamination efforts.*

Several of the reports did not contain comprehensive information regarding the events that led up to the use-of-force. At best, they included cursory summaries of de-escalation attempts that failed. The Department should consider and implement strategies to ensure that its staff memorialize specific information regarding force prevention, de-escalation, and decontamination efforts. The Department should explicitly require probation officers to provide detailed descriptions of the interactions between staff and youth that preceded the use-of-force incident, including the nature of the conflict that led to the use-of-force, any and all ultimatums provided by staff to the youth that was the subject of OC spray, and youth reactions to those ultimatums. Force reports should also include detailed descriptions of decontamination efforts — if they do not, they should be consistently returned to staff for revision.

Recommendation 8: *The Department should revise training materials to remove language that inadvertently encourages incomplete or inaccurate reporting.*

The Department should review existing training materials and remove any problematic language that encourages undesirable behavior. As described above, current materials include language that may unintentionally encourage staff to file incomplete use-of-force reports. Training should continue to emphasize the importance of complete, accurate, and truthful reporting of use-of-force incidents, including in situations where prohibited force may be at issue.

Department Policies

Recommendation 9: *The Department should establish a unified training and policy development team.*

The Department does not currently have a single designated team tasked with developing or amending its training and policies as needed, including those related to force. The Department has identified this need, and has worked towards assessing the resources it would need to create one. In reviewing,

revising, or developing trainings and policies, the team should strongly consider including timely input from line-level staff, outside experts, representatives of other juvenile justice systems, and representative community stakeholders, including formerly incarcerated youth and relatives of currently incarcerated youth. Active participation and contribution to the policy development process may also result in positive cultural change by enabling all interested parties to invest in and value the rules that guide their work.

Recommendation 10: *The Department should ensure that its use-of-force policies clearly define keystone concepts.*

The Department's current and draft use-of-force policies fail to provide clear and workable definitions for terms that relate to when staff are allowed to use force. For example, the draft use-of-force policy states that force can be used when staff are confronted by "ongoing defiant behavior" that leads to a "major disturbance," but neither factor is defined. Concrete definitions of these terms, and others, would assist staff in determining whether or not physical or chemical force is authorized.

Recommendation 11: *The Department should consider amending its draft use-of-force policy so that its force standard goes beyond the minimum requirements of the Constitution and other applicable laws.*

The Department's draft use-of-force policy states that force used by its staff will be assessed through the "objectively reasonable" standard established by the U.S. Constitution and relevant case law. However, some probation departments have chosen to go beyond the floor created by the applicable law in guiding the use-of-force. San Francisco, for example, requires its officers to generally apply the minimum amount of force necessary in all applications of force. The Department's draft use-of-force policy requires that its staff use the minimum amount of force necessary. The Department should also consider limiting the use of OC spray to instances in which staff are confronted by potential or actual physically threatening behavior. The draft use-of-force policy currently allows staff to use OC spray to gain compliance, which may contribute to avoidable deployments.

Some law enforcement agencies require that any force used be proportional to the risk of harm faced by the subject of that force, and that it correspond in degree to the seriousness of the objective at issue. The concept of proportionality is already implicit in some of the Department's policies — for example, the Department generally prohibits the use of OC spray when the subject youth suffers from certain physical or mental health conditions. Such restrictions are anchored in an understanding that OC spray results in actual and potential harm that may not be justified given the objective of the force. The

Department would likely avoid unnecessary OC sprays by requiring officers to weigh the harm caused by OC spray with the intended objective in each discrete incident.

Recommendation 12: *The Department should ensure its draft use-of-force policy prohibits troubling decontamination practices.*

Following the use of OC spray, the Department currently requires that staff remove the youth to a safe area following the application of OC spray, apply cold water to the face, and change clothing following an OC spray.[35] It also requires that staff present youth for a medical assessment within thirty minutes.[36] Conversations with staff and youth and force incidents reviewed by the OIG suggest that staff may be waiting up to thirty minutes or longer before initiating decontamination procedures. The draft use-of-force policy should guide staff in caring for recently sprayed youth who resist or refuse decontamination. Such resistance should not result in unnecessary delays to decontamination.

The draft use-of-force policy should also explicitly prohibit the following decontamination practices:

- Confining a youth to a room without running water within thirty minutes of an OC spray application;
- Turning off water to a room occupied by a youth who was the subject of OC spray;
- Providing a wet towel to youth who are attempting to decontaminate, and allowing those youth to rub their face;
- Using facility showers or faucets to decontaminate youth when staff lack the ability to control the temperature of the water; and
- Leaving youth unattended and without supervision immediately after the deployment of the first burst of OC spray.

Recommendation 13: *The Department should assess its policies regarding youth access to religious programming*.

Conversations with youth suggest that Department staff may be denying access to certain programs, including religious services. Some youth stated that they were not able to attend available religious services at Department facilities due to staff who believed they did not deserve such a privilege. The Department should ensure that its policies effectively prohibit such acts, and that its practices reflect policy.

[35] SCM Directive at 28.
[36] *Id.*

Recommendation 14: *The Department should require staff to act appropriately when observing policy violations and deviations from training.*

The Department's draft use-of-force policy requires staff to report potential violations. The Department should consider also requiring staff to immediately take affirmative action to try and stop inappropriate uses of force that they observe, and to take steps to correct the situation. Several incidents reviewed by the OIG involved staff who were passive witnesses to troubling violations of Department policy, and who failed to intervene. Creating this requirement will ensure that staff understand expectations regarding the use-of-force, and their role in caring for youth.

Recommendation 15: *The Department should assess its implementation of its HOPE Centers to ensure that it aligns with intended goals.*

Conversations with staff and youth suggest that the Department's HOPE Centers, which are designed to assist staff and youth in dealing with problem behaviors and to mitigate the use for force, may not be achieving their intended goals. The Department should assess its HOPE Center-related policies and practices, with a focus on ensuring adequate staff training and supervisor and management commitment to their effective operations.

Staffing

Recommendation 16: *The Department should continue assessing its staff resources, with an emphasis on ensuring that sufficient and effective supervision is provided to line-staff and youth.*

Conversations with staff and Department leadership revealed a consistent concern for day-to-day staffing levels and, as a result, the availability of experienced and effective supervisors during every shift. The Department should ensure that its staff needs assessment takes into account the experience level of available staff members, so that the teams that work together during shifts are led by capable staff. Similarly, such analyses should also take into account the potential needs of a youth population that may require one-on-one supervision.

Recommendation 17: *The DMH should work with the Department to identify specific mental health staffing needs and increase provider-to-youth ratios.*

The Department's use-of-force and de-escalation practices identify very specific and important roles for mental health professionals. For example, the SCM policy prohibits the use of OC spray on youth who are receiving psychotropic medication. The SCM policy also calls on staff to enlist the assistance of mental health professionals when attempting to de-escalate

situations that may lead to the need for force. Force prevention efforts that include mental health and other service providers, such as teachers and chaplains, tend to be more successful. Indeed, youth reported that some mental health providers were among the few individuals they trusted in facilities. The ability to provide adequate care, and to make good on force policy requirements, hinges on training and sufficient mental health staffing. However, most of the Department staff members and youth communicated strong impressions that mental health provider availability and support is inadequate.

DMH and the Department should assess existing staffing and services, identify any shortages or deficiencies, and rectify them. Adequate mental health staffing should include continuous, 24-hour care that allows for timely crisis intervention efforts, medication prescription and compliance monitoring, regular youth counseling, and sufficient availability to proactively assist in force prevention and de-escalation.

Culture

Recommendation 18: *The Department should continue to implement measures that ensure its practices are consistent with its core values, and to ensure that staff at every level work to create a safer environment in the County's juvenile justice facilities.*

The Department is led by specific and articulated core values, which include treating youth, staff, and the public with dignity and respect, and acting with integrity.[37] Available information suggests that the Department's values are not consistently being practiced by all personnel.

The Department should continue to address and refine its recruitment, hiring, training, supervision, and accountability practices to align with its stated mission. The Department should identify and procure resources necessary to adequately train existing personnel in effective behavior management tools that emphasize rehabilitation over punishment. The Department should identify and procure necessary resources to identify, recruit, and hire individuals whose professional orientation and expertise more closely align with rehabilitative rather than punitive principles. Department policies and procedures should establish clear expectations for staff-youth interactions in all aspects of youth confinement. Consequences for non-compliance and incentives for compliance should be clearly communicated and consistently enforced.

[37] Los Angeles County Probation Department Core Values.

Conclusion

The information and recommendations provided in this report are intended to inform both the Board and the Department of issues related to the use-of-force within the County's juvenile justice facilities. During its time-sensitive and focused review, the OIG identified several other factors that may impact the use-of-force in County juvenile justice facilities, including: facility conditions, labor agreements, staff morale, general resource allocation and constraints, and organizational culture, among other issues. Further assessments of these subjects is likely warranted.

cc: Sachi A. Hamai, Chief Executive Officer
Celia Zavala, Executive Officer
Mary C. Wickham, County Counsel
Terri McDonald, Chief Probation Officer

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MAX HUNTSMAN
INSPECTOR GENERAL

September 20, 2019

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

FROM: Max Huntsman
Inspector General

SUBJECT: REPORT BACK ON ENSURING SAFETY AND HUMANE TREATMENT IN THE COUNTY'S JUVENILE JUSTICE FACILITIES

On December 18, 2018, the Los Angeles County Board of Supervisors (Board) directed the Office of the Inspector General (OIG) to investigate safety concerns in the Los Angeles County Probation Department's (Probation) juvenile halls and camps, focusing on use-of-force incidents involving oleoresin capsicum (OC) spray (also known as pepper spray), and to report back with findings and related recommendations. The Board also instructed the OIG to address de-escalation tools and any staffing issues that impede de-escalation efforts. This report was provided to the Board on February 4, 2019. The OIG also issued a March 8, 2019, report-back assessing the use-of-force data collection and analysis practices.

On February 19, 2019, the Board further directed the OIG to prepare a follow-up report on safety concerns in juvenile justice facilities outlined in the OIG's February 4, 2019 report. This report summarizes perspectives derived from recent discussions with Probation staff and youth, assesses available data regarding staffing and the use-of-force, and evaluates Probation's efforts to address the OIG's previous recommendations.

Of particular concern to the Office of Inspector General are:

Staffing Allocation: Probation continues to experience staffing allocation issues in spite of a reduction in youth population of 58.7% from 2,052 in 2012 to 848 in 2019, while detention staff has been reduced by only 11.8%, from 2,455 in 2012 to 2,165 in 2019.

Data Collection and Analysis: Probation lacks sufficient information technology resources and methodologies to collect, store and access data in a meaningful manner. Resource-intensive processes severely hampered Probation's ability to provide the OIG all of the necessary information to evaluate Probation's staffing issues.

Internal Investigations: While staff and youth both have little confidence in the internal investigations process for widely divergent reasons, the allegations gathered by the OIG highlight the need for thorough, objective, and fair internal investigations and robust external oversight of Probation's investigative and disciplinary processes.

c: Terri McDonald, Chief Probation Officer
Sachi A. Hamai, Chief Executive Officer
Celia Zavala, Executive Officer
Mary C. Wickham, County Counsel

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Introduction

Probation is composed of approximately 6,000 staff members who work in field offices and facilities across the county, including juvenile halls, youth camps, and the Dorothy Kirby Residential Treatment and Placement Center (DKC), a secured, residential facility that provides enhanced mental health services for youth. Probation staff engaged in juvenile matters interacts with an average daily population of approximately 7,750 youth who are in its camps, juvenile halls, and placements and home on probation and in the community.

Probation currently authorizes staff to use OC spray in its two juvenile halls, Barry J. Nidorf Juvenile Hall and Central Juvenile Hall. It recently closed a juvenile hall (Los Padrinos Juvenile Hall) and two youth camps (Camp Ellison Onizuka and Camp Ronald McNair, both a part of the Challenger Memorial Youth Center) where OC spray was previously available to staff. Probation considers OC spray as its most serious authorized force option, with its use-of-force policy describing it as "the final and ultimate authorized" method to "gain control of a situation and/or subdue" youth.[1]

As with previous reports, Probation maintained an open and collaborative approach throughout the OIG's assessment. Probation personnel made themselves available and responded to information and facility access requests in a timely fashion. The leadership and staff of the offices of the Public Defender, Alternate Public Defender, and Los Angeles County Bar Association Independent Juvenile Defender Program observed and assisted with youth conversations. During those discussions, youth were accommodating, and spoke openly with OIG staff about difficult and complicated issues.

In response to the parameters of the Board direction, the OIG has neither verified nor independently investigated information detailed in this report provided to the OIG by youth and staff. To ensure anonymity and safety, the OIG agreed not to document identifying information unless a youth threatened harm to themselves or others.[2] Further, to be sensitive to the applicable rights and privileges of youth, representatives of the Public Defender, Alternate Public Defender, and the

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[1] *Id.* at 23.

[2] During interviews with youth, OIG staff did not inquire as to their identity or record their names. Probation was notified of this protocol. However, OIG staff debriefed with the most senior staff member of each facility after interviews of youth and staff and conveyed summary information regarding troubling allegations, without identifying sources.

Los Angeles County Bar Association's Independent Juvenile Defender Program were present during conversations with youth.

OIG staff received several accounts that, if true, serve as disturbing examples of policy violations by Probation staff. However, because the OIG lacks the authority to investigate and verify these accounts, only a limited selection are detailed below. Some of the events described to the OIG were investigated by Probation – but staff and youth consistently communicated a lack of faith in these investigations, albeit for widely divergent reasons. The seriousness of the allegations gathered by the OIG highlight the need for thorough, objective, and fair administrative investigations and robust external oversight of Probation's investigative and disciplinary processes.

Probation's most recent reports and draft policies reflect a clear commitment to continuing to address issues related to the use of force, accountability, and culture. One important task of the County's future approach to oversight, in whatever form it takes, should be to conduct a more definitive analysis of why staffing is so often attributed as a root cause of problems after a substantial reduction in youth-to-staff ratios.

Methods

The OIG's assessment of safety in the County's juvenile justice system involved staff and youth conversations, the review of draft policies, and assessments of particular Probation data. OIG staff also attended a de-escalation course provided to Probation staff, and reviewed accompanying educational materials.

The OIG requested and reviewed data related to staffing as well as Probation plans aimed at addressing recommendations previously made by the OIG. OIG staff visited every juvenile justice facility where the use of OC spray continues to be authorized. The OIG also visited Campus Kilpatrick and the Dorothy Kirby Center, two Probation facilities that provide care for youth with significant mental health needs and where OC spray is banned. In total, the OIG spoke with approximately 140 youth and 50 staff members, including managers and Probation leadership at these facilities.

Safety Concerns

Probation staff and youth throughout the County's juvenile justice facilities expressed continuing safety concerns. Staff shared concerns regarding the planned elimination of OC spray, staffing shortages, and perceived deficiencies in Probation's policies, practices, and training. Staff also discussed efforts to collaborate with facility medical and mental health providers and friction that has marred those efforts. Youth shared concerns about staff conduct, inconsistent access to programs, group punishment, and isolation of youth due to language barriers.

Safety Concerns Impacting Vulnerable Youth

Limited English Proficiency Youth

OIG staff spoke with several limited English proficiency (LEP) youth who shared stories of force they believe arose from an inability to communicate with staff. They also described situations in which they believe they were treated unfairly or inappropriately as a result of language barriers.

Government agencies have a duty to provide language access services to individuals who do not speak English as their primary language and who have a limited ability to read, write, or understand English.[3] The Civil Rights Act of 1964, and related regulations, require federal government agencies, and recipients of federal financial assistance, to provide certain language services for LEP individuals.[4] The federal government also provides guidance regarding LEP programs in correctional settings, and identifies model policies and principles.[5] According to the 2015 American Community Survey, conducted by the U.S. Census

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[3] LEP.gov, Commonly Asked Questions and Answers Regarding Limited English Proficient (LEP) Individuals, *available at* https://www.lep.gov/faqs/042511_Q&A_LEP_General.pdf (last accessed July 9, 2019).

[4] Recipients of federal financial assistance include state and local government agencies. Federal financial assistance takes many forms, including grants, training, use of equipment, donations of surplus property, and other assistance.

[5] LEP.gov, Considerations for Creation of a Language Assistance Policy and Implementation Plan for Addressing Limited English Proficiency in a Department of Corrections, *available at* https://www.lep.gov/resources/LEP_Corrections_Planning_Tool.htm (last accessed July 29, 2019.

Bureau, Los Angeles County has the highest concentration of LEP individuals in California, with approximately 2,379,799 LEP individuals who speak English less than "very well."[6] Sixty-eight percent of these individuals are Spanish-speakers, with Chinese- and Korean-speakers making up the next largest groups (nine and five percent respectively).[7] While Probation does not track LEP youth, the Los Angeles County Office of Education (LACOE) enrolled a total of 641 English-learners in the County's juvenile justice system throughout the 2018-2019 school year. According to Probation, it has 144 staff who are certified and receiving a bilingual bonus for utilizing their language skills in their assigned work.

Probation does not have sufficient language access policies that guide its staff in providing services for LEP youth or their families. Probation does have a policy that requires staff engaged in handling intake of youth at its facilities to seek out bilingual staff when necessary, but does not appear to provide any guidance beyond this. DMH has a general policy that provides staff with guidance on how to provide services to LEP individuals, but DMH staff with whom we spoke at the halls and camps were generally unaware of the policy's existence or requirements. As a result, DMH staff reported having to improvise strategies, including non-engagement, when interacting with LEP individuals. These strategies, according to the unverified accounts of youth, have led to mistreatment.

One Spanish-speaking LEP youth reported being subjected to OC spray after the youth failed to follow English-language orders that the youth did not understand. Staff then reportedly requested that the youth sign an English-language statement, which the youth did not understand. The youth reported signing the statement out of fear and confusion. On a different occasion OIG staff witnessed this youth attempting to speak with Probation personnel. Staff were unable to understand the youth, and the OIG observed a concerned Probation employee resorting to interpretation software on a personal cell phone to aid communication.

One LEP youth who recently arrived from Central America expressed belief that staff mistakes the youth's reliance on other Latinx[8] youth to communicate as a sign of gang-affiliation. The youth also expressed belief that this perception by staff

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[6] LEP.gov, Description of CA LEP Maps, *available at* https://www.lep.gov/maps/2015/county/html/CA_cnty_descr.ACS_5yr.2015.htm (last accessed July 9, 2019).
[7] *Id.*
[8] This gender neutral term is used in lieu of Latino or Latina (referring to Latin American cultural or racial identity in the United States).

leads to scrutiny and unfair treatment by staff. The youth reported being subjected to several instances of discipline that resulted from the actions of others.

One LEP youth described classroom time as a daily battle with boredom because the youth spends hours in front of an English-language computer that the youth cannot navigate. Another youth described being routinely left in a room while other youth attended educational programs, which the youth took as indication that staff do not see any value in providing access to such programs for LEP youth.

Youth also shared that Probation staff and other youth are often used as interpreters. The use of qualified staff interpreters is appropriate in particular situations, so long as the staff at issue are properly trained, certified and/or competent, and continuously assessed.[9] The use of youth interpreters who lack necessary training can lead to inaccurate translations, negatively impacting the quality or efficacy of day-to-day interactions and mental health services. Moreover, LEP youth who rely on staff or other youth to translate are denied the same privacy rights as their non-LEP counterparts. The practice of allowing youth to serve as interpreters can negatively impact power dynamics and leave some LEP youth at the mercy of their peers, since their access to necessary services is predicated on others who may use their advantaged position to the detriment of both staff and LEP youth.

Several LEP youth stated that they relied on both youth and Probation staff interpreters when visiting with mental health professionals in settings which were intended to be confidential. One youth stated that it was difficult to discuss emotional needs at length during mental health sessions when staff were used as interpreters, for fear that attending Probation staff might misunderstand or misuse the information shared. Probation reports that it does have telephonic intepretation services on hand to assist in these situations.

According to DMH staff, bilingual mental health professionals are used to provide services to LEP youth whenever possible but are not always available. DMH policies also call for staff to make use of telephonic interpretation services. Unfortunately, staff expressed unawareness of the availability of such services. One youth

[9] Federal Register, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, *available at* https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf (last accessed on August 5, 2019).

described several attempts to use available mental health services which failed because staff who routinely served as interpreters were absent or reassigned, and no alternatives were available.

Mentally Ill and Pregnant Youth

Youth with mental health needs reported being the subjects of OC spray. Some youth reported that they were, at the time of their respective incidents, awaiting transfer to the DKC. Such youth are recognized by Probation as having acute mental health needs. Due to resource constraints, youth who are assigned to the DKC have sometimes waited months at a juvenile hall before transferring. According to Probation, these wait times have recently improved to approximately two to three weeks. DKC staff are not authorized to carry or use OC spray.

Probation's data further suggests that the use-of-force on youth with mental health needs is a problem that merits further review. As detailed in the OIG's March 8, 2019, report to the Board, available data shows that Probation's Campus Kilpatrick, which is intended to provide trauma-informed care to youth, and the mental health-focused facility, the DKC, had the highest number of total use-of-force incidents during the 2018 calendar year when compared to other juvenile camps. Campus Kilpatrick had 101 incidents with an average daily youth population of 30, while DKC had 256 incidents with an average daily youth population of 49.

The OIG also spoke with youth who stated they experienced or witnessed the use of OC spray on other vulnerable populations, including pregnant youth.

Systemic Safety Concerns for Youth and Staff

Elimination of OC Spray

The OIG spoke with both youth and staff about the anticipated elimination of OC spray. At the time of the conversations, Probation had yet to publish its approach to phasing out OC spray, submitted to the Board on June 21, 2019.

Several staff in the juvenile halls were surprised to hear that in February 2019, the Board ordered the elimination of OC spray and were under the impression that Probation was still exploring whether such a change was merited. Others reported frustration with the planned elimination and complained that staff who are most affected were not consulted in developing a proposed plan to phase out OC spray,

or in modifying existing use-of-force policies. Some staff cited these perceptions as contributing to low morale. Probation leadership reports that it is holding focus groups and town hall meetings with staff, and that staff in each housing will receive specialized training and opportunities to communicate any concerns about the OC phase out plan.

Some staff shared concerns that the elimination of OC spray would make the juvenile halls less safe. Staff expressed a generalized sense of hopelessness about dealing with youth who are either non-cooperative or who are actively assaultive. A common staff concern was the inability to react effectively to larger disturbances involving multiple youth. This concern was compounded by reports of staffing issues and difficulties resulting from transferring youth following the closure of Los Padrinos Juvenile Hall and other facilities. Multiple staff expressed the belief that the potential use of OC spray deters youth from fighting. Some youth echoed the concern that more fights would occur if OC spray were removed.

Other staff were hopeful that the elimination of OC spray would improve conditions. Those employees, however, stressed the need for more robust and effective de-escalation training, and clearer policies and training on dealing with youth with mental health and behavioral needs. Several staff also requested a need for more effective guidance in dealing with gang-affiliated youth.

Generally speaking, youth were pleased and more optimistic than staff when discussing the elimination of OC spray. One youth, who was previously subjected to OC spray, stated that the elimination would remove an impediment to constructive relationships between youth and staff. Another youth, with an allergy to OC spray, described experiencing uncomfortable skin irritations for weeks following exposure to OC spray. The youth described being so afraid of OC spray that the youth frequently attempts to de-escalate or break-up fights as an attempt to mitigate the need for staff to use OC spray. The youth was relieved to hear that the substance would no longer be in the facilities.

Staff Morale

Probation staff continued to express low morale, which may be exacerbated by a perceived lack of sufficient staffing and a distrust in existing accountability structures. In our recent discussions, staff continued to report frustrations with the uncertainty surrounding departmental changes, disruptions caused by the closure of facilities, staffing issues, and inadequate training.

Staff overwhelmingly shared a fear of reprisal by management following any use of OC spray, as opposed to the use of other force. Several staff reported that the concerns stem from the discipline and arrests of six probation staff in April 2019 for the alleged unreasonable and excessive use of OC spray on several youth in their care. (These incidents were discussed in the OIG's February 4, 2019, report-back to the Board). Generally, staff stated that they believe these arrests were unjustified. As a result, many staff members believe they will be unreasonably disciplined, or criminally prosecuted, for the slightest use of force even if the force is lawful.

According to staff, fear of unjust discipline has led to the failure of some colleagues to properly perform their job duties. Both staff and youth reported that some Probation members refuse to intervene during youth disturbances, including physical altercations between or among the youth. The staff members that refuse to take action have been reported to walk away from an incident or only provide instructions while seated. This lack of engagement contributes to increasing tensions between staff, making it more difficult for these staff to work well together and maintain safety.

Youth are aware of the low morale among staff. One youth remarked that some staff are there because they care about the youth while others are there to collect a paycheck. Staff inaction may lead to youth feeling less safe, contribute to their anxiety, and aggravate mental health issues. This may also contribute to misbehavior, since some youth may seek to take advantage of staff who fail to act.

Staffing Issues

Both staff and youth complained about staffing at Probation facilities, an issue that was previously identified in the OIG's February 4, 2019 report-back. Staff reported feeling overworked and exhausted. Staff also shared that they experienced reoccuring difficulty in appropriately completing job duties, including escorting youth to programing and responding to disruptive incidents. According to staff, this has led to increased safety concerns and frustration by both youth and staff as further discussed below.

Staff conversations suggest that staffing shortages are contributing to anxiety and uncertainty in the performance of job duties. One staff member described struggling to respond to youth disturbances because of insufficient staff support. These staff are confronted with a difficult choice: (1) intervene at the risk of their own personal safety, or (2) wait for staff support that may be delayed, putting the safety of youth at risk. Either way, these situations may contribute to the use of

improper force and avoidable staff and/or youth injuries. According to one staff member, these problems are intensified by unclear policies and insufficient training that fail to provide sufficient guidance in such situations.

Several staff and youth reported that staffing issues often prevented youth from attending school or religious services. Many youth at Barry J. Nidorf Juvenile Hall complained that academic lessons were often provided in their respective housing units, instead of in on-site classrooms, and stated that staff cited staffing shortages as the cause. Youth reported this was often the only time they were out of their rooms. According to youth, the lack of a dedicated school environment makes it more difficult to concentrate and affects student motivation and participation. Youth also reported that chaplains sometimes conducted services in the housing units when insufficient staffing prevented transportation, which many youth expressed did not provide the same sense of spirituality or community. These situations may contribute to disruptive incidents.

Staff and youth also shared that youth are often unable to participate in other programs, outdoor recreation, and day room time, with staffing issues consistently cited by both as an impediment to being able to safely escort or supervise the youth. Some youth reported not participating in outdoor recreation time for significant stretches of time, spanning from days to weeks. Probation leadership reports that it has improved youth participation in programming at Barry J. Nidorf Juvenile Hall.

Staffing Data

Accounts describing staffing issues are further supported by available data and conversations with Probation management. Although usable data on the issue is limited, the data reviewed by the OIG suggests that recent facility closures and staff reassignments have not eliminated staffing pressures within Probation facilities, in particular the juvenile halls. As a result, Probation is increasingly reliant on overtime hours to maintain adequate staffing.

Probation saw a significant drop in the total youth population in its care from 2012-2019. During that time-frame, the number of staff with duties including the direct care of youth in its juvenile halls and camps remained fairly consistent, with a drop in available budgeted staff beginning in 2017. Staff, relying on anecdotal observations, have attributed this drop to facility closures and resulting staff transfers to positions that do not involve the direct care of youth. They also cited attrition. The following chart, derived from data provided by Probation and verified

using other information, shows the recent change in line staff compared to the number of incarcerated youth.

	2012	2013	2014	2015	2016	2017	2018	2019
Youth Population	2052	1745	1530	1373	1183	1118	939	848
Line Staff	2455	2553	2553	2553	2553	2551	2363	2165

While the data above shows a larger than 50% drop in youth population and a drop of only 12% in available staff, staff shortages have increasingly been reported as a cause of problems in facilities. To better understand staffing pressures Probation currently faces, the OIG requested data regarding staff vacancies and absences affecting the direct supervision of youth. Probation cooperated fully with OIG requests, but limited information technology systems and resource-intensive processes severely hampered Probation's ability to provide all necessary information. One request by the OIG for data related to planned and unplanned staff absences required Probation to manually extract data from paper documents, as this information was not readily available in electronic form.

The OIG received data related to long-term leave pursuant to the Family Medical Leave Act (FMLA), as well as unplanned short-term leave taken by staff with direct supervision over youth.[10] The available data reviewed by the OIG suggests that Probation is struggling with both long-term and short-term staff absences which may negatively impact its ability to provide consistent youth access to programs and activities. OIG staff were informed by Probation leadership that in order to meet the needs of the facilities, available personnel are required to work over-time and assume extra duties during their shifts.

The use of temporary staff to fill unplanned absences likely impedes the rapport between youth and staff that is necessary to effectively respond to critical scenarios with de-escalation methods. As explained below, staffing issues are also likely to lead to an increase in youth spending time locked in their rooms, which may increase tensions between youth and staff. Finally, relying on staff overtime may

[10] The FMLA requires some employers to provide employees with job-protected and unpaid leave for qualified medical and family reasons. Unlike short-term and unplanned leave, FMLA leave is generally requested and approved some time before it is used.

further tax employee temperament and performance, creating situations in which fatigued personnel are asked to deal with complex and high-stakes situations.

Youth Perceptions of Probation Culture

Low morale and exhaustion among Probation's line-level staff can contribute to unsafe environments within the County's juvenile justice facilities. Many youth shared that staff appeared dissatisfied with their jobs. Multiple youth from various facilities reported believing that the apathy of staff contributes to health and safety issues in the facilities. These youth cited to the OIG examples of staff inattention and failure to address problematic violent behavior by other youth.

Some youth also reported a perception that staff were unprofessional, disrespectful, and callous, imposing arbitrary discipline, inciting disturbances among the youth, displaying favoritism and inappropriate taunting and teasing based upon race, religion, ethnicity, and medical or mental condition and expressions of political beliefs, name calling and use of profanity when addressing youth, and the sharing of confidential personal and health information with other youth.

The OIG received other accounts of alleged mistreatment of youth. As stated above, due to the nature of this review, the OIG has neither verified nor independently investigated these accounts or alleged staff statements. Some youth shared examples of staff arbitrarily disciplining some youth but not others. Youth also described staff who incite disturbances among the youth, and staff who fail to intervene when youth are fighting.

Some staff also reportedly favor some youth, occasionally along racial lines. This favoritism reportedly ranges from staff permitting youth to provoke fights without attendant consequences, to staff providing fast food, additional snacks, phone calls, and other privileges to some youth.

Relatedly, some youth reported inappropriate teasing by staff that was reminiscent of issues identified in the OIG's February 4, 2019 report-back. Staff members often build rapport with the youth through friendly banter and teasing. However, some youth found that some staff members took the teasing too far, making youth uncomfortable and embarrassed. Some youth reported that staff have called youth by names of a different gender or that they taunt youth. Some youth reported cursing by staff who are directing youth.

Some youth reported the failure by staff to timely respond to bathroom requests when they are locked in their rooms. The majority of rooms at the County's juvenile halls lack bathrooms, requiring youth to knock or yell to get the attention of staff. As a result, some youth reported that they must relieve themselves in any available containers. Close review of CCTV footage will be an important oversight tool to verify these and other youth reports to the OIG.

Group Punishments and Bystander OC Exposure

OIG staff received several reports from youth who described experiencing collective punishment, which was briefly discussed in the OIG's February 4, 2019 report-back. Collective punishments are acts of discipline that affect more individuals than those whose acts triggered the need for discipline. Probation has policies that bar such punishments.

Youth at each of the juvenile halls described long stretches of time confined in their rooms during daytime hours due to the acts of a few. As a result, youth reported that they were unable to attend educational classes, programs, and participate in recreation time. Staff conveyed similar scenarios, citing the inability to address problem behaviors by youth and staffing issues as justification for the actions.

As with the OIG's first report, youth described the indiscriminate use of OC spray deployment within small, enclosed spaces, resulting in secondary exposure. Several youth provided examples of staff failing to allow for timely decontamination, or of staff failing to interview the exposed youth as part of subsequent use of force investigations. Reports of secondary exposure to OC spray included some youth who reportedly suffer from asthma.

One staff member – who expressed reticence to use OC spray due to its ill effects – reported receiving strict guidance to use OC spray whenever a youth misbehaves. The staff member took this as strong encouragement to always use force as the initial option, without considering less alternative means.

In addition, youth continued to report delays in decontamination and inappropriate efforts to decontaminate following the application of OC spray. Several youth reported waiting up to thirty minutes before staff allowed them to decontaminate.

Training

Probation staff continued to stress the need for more tailored training opportunities that reflect the day-to-day needs of staff who work with youth directly. Many staff bluntly stated that they felt underprepared to do their jobs without OC spray, with several specifically requesting enhanced training courses related to de-escalation, crowd control, mental health, and addiction services.

As previously reported, Probation is implementing multiple short and long-term training initiatives, including a training and technical assistance program organized and provided by qualified consultants. Probation is also providing more frequent non-violent crisis intervention de-escalation training.

OIG staff observed Probation's refresher non-violent crisis intervention training course, focusing on assessing training content and interactions between trainers and trainees. The training made use of materials from an outside vendor, but was administered by Probation staff. Overall, the material was comprehensive, providing clear descriptions use-of-force techniques. Materials also touched on trauma that may affect staff members, and resources available to help those in need.

OIG staff observed class room discussions and hands-on scenarios. The trainers were engaging and demonstrated clear mastery of the material. Most staff seemed to engage earnestly with the material and presentations. Classroom discussions touched on use-of-force policies and trauma-informed care practices. At times, the conversations indicated deep-seated and worrisome confusion about Probation's use-of-force policies among line-level ranks. This confusion was evident during a discussion of Probation's core use-of-force policy, which distinguishes situations that may merit the use-of-force as "controlled" or "uncontrolled."

The instructors discussed several scenarios and invited the trainees to classify each scenario as "controlled" or "uncontrolled." One scenario, which involved a youth who spat at staff and then immediately complied with orders to cease, demonstrated conflicting understandings of applicable policy and relevant law. Several staff members incorrectly believed this was an "uncontrolled" incident and stated that Probation's policy allowed them to use force, even when the youth completely ceased all aggressive behaviors. When instructors pointed out that the policy only allowed staff to rely on force if a youth was actively assaultive or destroying property, several staff members expressed shock and argued that the

practice was previously allowed. In fact, Probation's policies do not and have not previously allowed force to be used in such situations.

Programs

Effective programs are an essential factor to creating safe juvenile justice facilities, since they provide youth with constructive outlets for time, energy, and attention. However, youth in various units throughout Probation's facilities complained of inadequate educational experiences and of a lack of programming after school and on weekends. Based on conversations with staff and youth, this appears to be the result of frequent no-shows or cancellations by volunteers, short staffing, and/or the limited availability of diverse programming.

According to information provided by Probation, youth have acces to various programs, including reading courses, Alcoholics Anonymous, academic tutoring, arts and crafts, music, continuing education including college courses, work programs, dancing, yoga, and similar extra-curricular classes, but not all facilities offer each course. While some facilities may offer some programs in life-skills, career skills, and mental health, youth reported a general lack of programs related to personal development and behavior modification. The majority of youth requested more quality programming that would help them better cope with difficult situations or programs that would help them find jobs when they transition out of the County's juvenile justice facilities. A few youth, who reported only having access to addiction counseling related to alcoholism, also specifically requested general addiction counseling.

Some youth reported that limited programming resulted in youth spending several hours a day bored and locked in their rooms. Some youth reported that though they do not suffer from dependency problems, they attend Alcoholics Anonymous meetings simply to escape boredom and isolation of their locked rooms. One youth stated that the lack of programs causes boredom, contributing to tension in the units and leading to more disturbances and uses of force.

While youth at the camps reported slightly more program options than their counterparts at the halls, these youth reported also spending a significant portion of time playing video games or watching television after school.

Youth also expressed concerns about insufficient family engagement. Youth shared that family visits are limited to weekends, and that they are generally only allowed

one 15 to 30 minute phone call per week to their families. Probation confirmed that these are the minimum visits and phone calls allotted to youth, but report that families are also able to visit with youth after court hearings and during special holiday events. Some youth reported the opportunity to make additional phone calls, but these exceptions were reportedly provided to youth at Campus Kilpatrick, to youth who were favored by staff, or as an incentive for good behavior.

Grievances

As previously discussed in the OIG's February 4, 2019 report-back, the majority of the youth who spoke with OIG staff continued to be critical of Probation's grievance system, particularly when it involved staff misconduct. Youth expressed a lack of confidence in the grievance system and generally criticized it as unresponsive, untrustworthy, and therefore ineffective. Many youth reported filing grievances containing serious allegations, such as excessive force by staff and fear of assault by other youth, that they believe went ignored, were not investigated, or led to biased investigations.

Many also reported fear that filing a grievance would lead to retaliation, including staff action that would negatively impact their criminal cases. Moreover, some youth reported a stigma perpetrated by staff that only "snitches" use the grievance system, which carries the possibility of negative consequences. While Probation provides locked boxes for youth to file grievances, the boxes are often located directly in view of staff stations. Thus, there is a perception among youth that staff take note of who submits grievances, contributing to fears of retaliation that lead to underreporting.

During OIG discussions, multiple youth alleged sexual misconduct by a particular staff member. All the relevant youth provided the same description of the staff member. One youth who directly complained about this conduct to Probation staff felt that staff did not believe or effectively investigate the allegations. According to another youth, Probation allowed the staff member to continue interacting with female youth who had complained about his conduct.

The OIG brought these allegations to the attention of a senior Probation manager, who shared the belief that Probation had investigated the conduct and that the facility trusted its grievance system to bring such accusations to light. Unfortunately, some youth conversations suggest that trust is not shared. Probation is currently reviewing these allegations and conducting an investigation.

On March 1, 2019, Probation and LACOE created a pilot initiative at DKC to allow youth to submit grievances on the school computers with the option to either provide their names or to do so confidentially. According to Probation, the pilot was recently expanded to include all facilities. External tracking and monitoring of grievances and grievance data will be an important aspect of Probation's external oversight.

Mental Health Programs

Mental health programs are an essential part of the County's juvenile justice system. Most youth reported regular visits with their psychiatrists and received psychotropic medications in a timely manner. Most youth also reported regular therapy sessions and believed they could have additional sessions at their request. Moreover, unlike Probation's grievance system, the youth had no concerns with submitting mental health request forms and shared that the forms were responded to appropriately and without significant delay.

Probation reports that services are available at all facilities on the weekend, including one on one and group sessions. However, some youth did express experiencing difficulty scheduling therapy appointments due to the unavailability of therapists, while others reported that therapy sessions felt rushed at the end of the day. One youth shared that a therapist is frequently unavailable and often provides only five-minute sessions. This youth wanted additional time with the therapist but felt hopeless given the provider's busy schedule. Moreover, both youth and staff expressed frustration with the lack of DMH staff available on nights and weekends.

Some youth reported dissatisfaction with their therapists and shared that it was difficult, if not impossible, to change providers. One youth believed his therapist was more concerned with lowering his mental health classification than providing meaningful treatment, likely because of staffing pressure. Youth who disfavor their therapist are not likely to build the necessary rapport for effective therapy, likely mitigating the effectiveness of the treatment.

Staff and youth also reported that DMH staff generally do not approach youth experiencing a mental health or behavioral crisis until the youth has calmed down, or unless the youth has expressed explicit suicidal ideations. This stands in contrast to Probation policies, which require staff to make use of mental health care providers in attempting to de-escalate situations and mitigate the need for force.

When DMH staff are not able or willing to carry out said tasks, it effectively forces Probation staff to address mental health situations they may not be appropriately trained to handle.

Based on the OIG's discussions with staff, Probation and DMH may not be effectively preparing staff to identify and engage with youth during a mental health or behavioral crisis. For example, one Probation staff member reported not feeling prepared to differentiate between a mental health crisis and behavioral issues – leading to confusion about when to request DMH assistance. There may also be disagreement among DMH and Probation staff about what constitutes a mental health crisis. This ambiguity could effectively be the reason DMH staff may not be responding to what Probation staff believe is a mental health crisis. Whenever possible, the distinction between mental health needs and behavioral issues should be made clear in order to provide a tailored approach to crises.

Probation confirms that once a youth's medications are verified by nursing staff with parents/legal guardians or placements, the medications are continued immediately by a psychiatrist (usually within 24 hours of entering the hall). Typically, youth are seen for psychiatric intakes within 3-5 days. However, a few youth reported waiting anywhere from seven to eighteen days before receiving medications previously or newly prescribed to them in the community. Such delay in medications may lead to serious consequences, including behavioral issues and treatment regression.

Trauma-informed and Mental Health Facilities

As recently reported by DMH, the County's juvenile justice system cares for a significant number of youth with mental health needs.[11] In 2018, 85% to 96% of the County's juvenile hall population received ongoing mental health services.[12] Probation currently operates two facilities, the Dorothy Kirby Center, designed to provide services to post-adjudicated youth with serious mental health needs, and Campus Kilpatrick, which focuses on trauma-informed care. OIG staff visited both facilities and spoke with staff and youth.

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[11] *Report Response on the Office of Inspector General Investigation and Improving Mental Health Treatment and Safety in the Juvenile Facilities,* Department of Mental Health (April 26, 2019), *available at* http://file.lacounty.gov/SDSInter/bos/supdocs/137012.pdf (last accessed July 11, 2019)
[12] *Id.* at 3.

Campus Kilpatrick

Campus Kilpatrick, previously located in Malibu, is Probation's fullest expression of the "L.A. Model." The model is centered on a small-group treatment approach, predicated on trauma-informed care and geared towards serving youth with a range of mental health, medical, and substance abuse needs. The approach is designed to facilitate and make use of input from youth, family, Probation staff, and mental health professionals, among others. Staff at Kilpatrick are vetted and trained to provide care that is in line with this approach.

Due to damage caused by the Woolsey fire, Kilpatrick was recently relocated to the Challenger Memorial Youth Camp (CMYC) complex in Lancaster. According to youth and staff, the program's transition has caused a host of issues, including staffing shortages, concerns about facilities, and difficulties arising from Kilpatrick and CMYC staff working together.

The currently unoccupied Kilpatrick facility has open-dorm style housing, divided into "cottages" of no more than twelve residents each that are designed to facilitate group engagement and care. The facility also includes rooms intentionally designed to enrich mental health care, programs of various kinds, and visits from family. In contrast, according to staff and youth, CMYC facilities make it difficult to foster a caring environment. According to some DMH staff, available communal spaces are not designed in line with the precepts of the L.A. Model, and spaces for mental health visits are not sufficiently private, making it difficult for youth to fully engage with mental health providers.

According to staff, several Kilpatrick staff have been on leave since the Woolsey fire, while Probation reports only one staff has been on leave since the fire. CMYC staff report that, as a result, they must work over-time and supervise Kilpatrick youth. OIG spoke to DMH and Probation staff who stressed the culture clash this routinely creates – leading to conflicts between Kilpatrick and CMYC staff arising from differing driving principles that guide their interactions with youth. One Kilpatrick staff member stated that the CMYC staff import punishment-based, "old-style" approaches to Kilpatrick youth. One CMYC staff member felt that Kilpatrick youth were allowed to run-amok, without structure or consequences for their actions. According to DMH staff, meetings meant to ease these tensions and create unity among County staff are poorly and irregularly attended by CMYC staff.

Staff shared various other accounts of tension among County personnel at Kilpatrick. For example, one Probation employee from Kilpatrick indicated that DMH staff are often unavailable or unwilling to help de-escalate conflicts between staff and youth, potentially increasing the likelihood that force will be used. Conversely, a DMH staff member stated that Probation staff mistrust mental health professionals, in part because such staff recently reported problematic behavior by Probation staff. In what was perceived as retaliation, that DMH staffer reported that Probation staff member kept a DMH member confined to a locked room with youth longer than was necessary.

Despite these issues, Kilpatrick youth expressed satisfaction with the mental health services they are receiving. Youth consistently reported routine and constructive mental health consultations and group sessions. Unlike other youth from other Probation facilities, Kilpatrick youth reported being able to see mental health professionals consistently on the weekends. Most significantly, youth reported constructive relationships with Kilpatrick staff, and consistently stated that they were generally treated with dignity and respect.

Kilpatrick staff spoke longingly and optimistically about returning to the Malibu site. They generally described their experiences positively, suggesting that Probation's efforts to transform the culture and services for youth at that facility were working at that site.

Dorothy Kirby Center

The DKC, located in Commerce, is a secure facility where Probation, DMH, Probation Health Services, Department of Health Services' Juvenile Court Health Services, and LACOE work together to provide youth with intensive behavioral therapy geared towards treating those with substance abuse and mental health needs. The facility houses approximately 70 youth, with a reportedly significant waiting list for those assigned to the facility. Both youth and staff are vetted before joining the facility.

Staff and youth reported high-levels of satisfaction with their experiences at DKC. Both consistently cited the positive relationships that staff and youth are able to form and maintain at the facility. According to DKC leadership, staff are encouraged to engage with youth in a manner that fosters mutual respect, communicating with care, identifying and satisfying youth needs, and avoiding insults. For example, one youth recounted a therapist who, after learning that the youth's family was unable to travel to the facility because of cost, provided money for transportation. Another stated that a therapist took extraordinary steps to mediate a conflict between the

youth and the youth's mother. Examples like these likely contribute to the bonds that maintain satisfaction at DKC.

Youth also consistently cited "a feeling of freedom" at DKC that differs from the juvenile halls and other camps. Some cited a lack of unnecessary instructions or arbitrary control by staff. In contrast, one youth stated, staff at other facilities seek to control youth in arbitrary and needless ways, issuing commands to youth that are seemingly unrelated to maintaining order and safety. One youth stated that staff at DKC were "on [the youth's] side." Fostering an environment that is perceived as being metered and fair, while maintaining necessary order and safety, likely serves as an ingredient of DKC's success.

Youth also positively cited the availability and diversity of quality classroom instruction and after-school programs at DKC. As discussed elsewhere in this report, programs were cited as beneficial to maintaining youth morale, and providing constructive out-of-room experiences. Programs not only make use of youth energy and time in a purposeful way, they also contribute to successful youth transitions from the juvenile justice system to home-life. For those reasons, some youth did report frustration with waiting lists for programs.

Probation and DMH staff at DKC generally praised one another's collaborative attitudes and approaches, which likely contribute to a well-functioning mental health services system at the facility. Youth reported consistent visits with their mental health providers, and fast responses to mental health service requests. DMH staff expressed a feeling of comradery with Probation staff.

DKC's apparent success may be due, in part, to its unique approach to staff schedules. Unlike other Probation halls and camps, staff at DKC must work a traditional forty-hour week, across five days, while staff at other camps mostly work a three-day, fifty-six-hour week. During those three days, staff generally work more than eighteen hours a day. Compressed work schedules may negatively affect the mood, performance, and temperament of Probation staff, while also interfering with the kinds of relationships that form from routine interactions. In contrast, managers at DKC believe that traditional work schedules likely facilitate strong bonds between youth and staff by allowing line-officers to be consistently present in the facility.

Recommendations

The OIG presents the following recommendations, which are based on information collected through its review of relevant policies, and its conversations with staff and youth. The OIG also reviewed Probation's OC Phase out Plan ("Plan") and Probation's responses to the OIG's February 4, 2019 and March 8, 2019 recommendations, submitted to the Board on June 21, 2019. The Plan and draft policies are clearly the product of a careful and earnest effort to move Probation forward. In an effort to assist with this process, following the OIG's review of Probation's Plan and draft policies, the OIG has identified areas for further consideration below.

The OIG also reviewed the Probation Reform Implementation Team's "Summary Report of the Los Angeles County Probation Systemic Reform Plan," issued on August 9, 2019. The report synthesizes the various recommendations made by stakeholders who have reviewed Probation policies and practices throughout the year. The OIG's recommendations below are intended to further inform these recommendations.

Recommendation 1: Probation should work to more effectively involve its line-staff in its continuing efforts to eliminate OC spray, and work to address misconceptions about its accountability processes.

The OIG reviewed Probation's OC phase-out plan while it was in draft form and the final document which was made public in late June. Nonetheless, the OIG spoke with several staff members who still felt confused about Probation's plans and actions to eliminate OC spray. Some were also outwardly hostile to the elimination of the force technique. Organizations that go about developing and implementing significant changes benefit tremendously when they tap internal expertise to inform their transitions. Such efforts may also win-over staff who are not convinced the changes are necessary or beneficial.

Probation should ensure that its elimination of OC spray, and its assessment of those efforts, includes sustained substantive input from staff who supervise youth on a regular basis. Such efforts should go beyond town hall-style gatherings or meetings with labor representatives, and should be aimed at empowering staff.

Moreover, in the interest of securing the benefits of continuing education and improving staff culture, whenever possible based on applicable law, Probation

should communicate information and materials to its staff relating to misconduct and potential consequences, including discipline and criminal prosecution. To gain back staff trust, Probation should also identify common misconceptions about its accountability processes and provide information that dispels these concerns.

Recommendation 2: Probation should create additional language access policies to serve youth with limited English proficiency, and ensure that resources are available to provide certified and professional interpretation and translation services when needed. DMH should ensure that its policies are understood and implemented by its staff.

According to information provided to the OIG, Probation lacks sufficient policies and consistent practices to guide staff working with LEP youth. Probation's current policy only provides guidance to staff within its juvenile halls, expressly within the context of the initial admission and intake of youth. As a result, and as observed by the OIG, staff and youth in other settings rely on various ad hoc strategies to engage with said youth. These informal methods have caused LEP youth in the halls and camps to consistently report feeling unsafe and misunderstood by staff, as well as underserved by available mental health programs that are not accessible due to language barriers.

Probation should rectify this situation by identifying and tracking youth who have language access needs, determining how to best meet their needs, and improving its policies to adequately guide staff when working with this youth population. Specifically, Probation should work to better equip its staff, including those in its camps, with necessary resources, including access and understanding of interpretation and translation services, to effectively interact with said youth and enable them to make use of beneficial programming, including that related to mental health. To that end, interpretation and translation services should be selected based upon generally accepted practices. Probation should also ensure, whenever possible, that relevant bilingual staff are available during every shift in its facilities.

DMH should similarly work to ensure its policies are understood and followed by staff. OIG spoke to several DMH staff members, both at Probation's halls and camps, who were unaware of existing DMH policies governing services for LEP youth and their families. Such staff were also unaware of available resources when bilingual staff are not on hand.

Recommendation 3: Probation should work to ease the transition of Los Padrinos Juvenile Hall youth to its remaining juvenile halls.

The recent closure of Los Padrinos Juvenile Hall has led to the reassignment of youth throughout Probation's remaining juvenile halls. Probation should ensure that its housing practices at Barry J. Nidorf and Central juvenile halls take into account necessary factors to ease transitions, including mental health needs and familiarity with other youth or staff.

According to staff, some of the transferred youth have been housed in units that may increase the likelihood of youth-on-youth violence due to a failure to account for neighborhood or gang-affiliations. Probation should explore strategies to address this issue.

Recommendation 4: Probation should work to mitigate the negative impacts of its staffing issues and continue working to marshal further resources to ensure appropriate staffing.

As detailed above, staff and youth discussions consistently touched on a perceived staffing crisis within the County's juvenile justice facilities. Based on overall numbers, the doubling of staffing ratios due to reductions in numbers of incarcerated youth raises the question of whether staff are efficiently allocated.

Probation should continue to develop and improve its information technology systems. Probation currently relies on a decentralized and informal paper-based sources to gather metrics on staffing and absences. This makes it difficult for Probation to identify what is contributing to staffing issues and to then act to address those causes. Probation should seek to collect all relevant information. , and should explore ways to poll its staff to identify whether there is a connection between morale and absences.

When Probation relies on staff overtime hours to address staffing issues, it should do so with the welfare of both staff and youth in mind. Probation should limit the number of overtime hours staff are permitted to work within a prescribed amount of time, and it should ensure that staff are providing effective services during overtime shifts.

Probation should also explore, in collaboration with its labor partners, changes to its staffing schedules. Just as overtime may negatively influence the quality of staff

interactions with youth, 56-hour block shifts are also likely exacerbating staffing resources and contributing to underperformance by staff. Probation and its labor partners should study the Dorothy Kirby Center, assess the impact of a more traditional work week, and modify work schedules.

Recommendation 5: Probation should expand its youth program offerings, including facilitating more frequent and meaningful interactions with family.

As detailed above, several youth expressed dissatisfaction with the breadth and availability of programs within the camps and halls. Probation should assess the demand and impact of its programs, which would enable it to right-size or eliminate existing offerings. Such efforts should be meaningfully informed by youth currently within the juvenile justice system, and those who have previously spent time in a juvenile hall or camp. Probation should also continue to work with outside stakeholders to provide programs that reflect the needs of youth in its care, with a focus on imparting skills that will enable youth to succeed during their time within Probation's care and beyond.

In addition, Probation should provide programs that facilitate improving familial relationships and support, where necessary. It should also provide youth and their families' additional opportunities to interact more frequently.

Recommendation 6: Probation and DMH should continue working collaboratively to improve mental health services.

While the majority of youth appear to be receiving the appropriate care and treatment, Probation should implement a quality assurance program to ensure that all youth receive the appropriate mental health care and treatment they need.

Probation and DMH staff reported confusion and tension about de-escalation efforts. OIG conversations revealed a lack of clarity as to when DMH staff should support Probation staff in de-escalating tension with youth. While Probation policies are clear that such attempts should be made whenever possible, members of both agencies communicated confusion as to when and how to carry out such attempts.

The two agencies should also work to establish and issue guidance on collaboration between respective employees. Some staff spoke openly with the OIG about tension and uneven engagement across DMH and Probation, a situation that likely mitigates some of the promise of the L.A. Model; benefits that could result in

improvements for the work life of staff and youth experiences. As a part of this, both departments should explore how to facilitate information-sharing between their respective employees.

Furthermore, as detailed above, Probation should work to understand the types of force used against youth with mental health needs, the potential relationship between its use-of-force and the mental health needs of youth, which may be the cause of problematic youth behaviors, and should explore strategies and programs that may empower its staff to deal with behavioral issues without resorting to force.

Recommendation 7: Probation should continue working to expand the L.A. Model and its efforts to mitigate the negative impact of Campus Kilpatrick's transition to the Challenger Memorial Youth Complex.

Youth and staff at each of the facilities visited by the OIG stressed the positive impact of constructive relationships on avoiding the use-of-force within the juvenile justice system. Maintaining those relationships is a foundational cornerstone of the L.A. Model. To that end, Probation should continue expanding the L.A. Model throughout its halls and camps.

As detailed above, recent wildfire damage has led to the relocation of Campus Kilpatrick from Malibu to Lancaster. With that transition, according to staff, some of the programmatic and cultural characteristics that made Campus Kilpatrick a uniquely effective expression of the L.A. Model were dampened. Probation should work to address this by ensuring that any staff, including staff on loan from other facilities, who work with Kilpatrick youth, are staff that agree and buy-into the Kilpatrick model of trauma-informed care.

The transition to Lancaster has also placed Kilpatrick youth in physical facilities that are out-of-step with the facility's ethos. Youth are no longer living in a building that facilitates group therapy sessions and constructive programs. Probation, where feasible, should work to address this by repurposing available space in a manner that increases the efficacy of mental health and behavioral therapies. Semi-private spaces should be found and used for mental health services. Common spaces should also be outfitted to facilitate group conversations.

Recommendation 8: Probation should ensure that its proposed force accountability teams have clearly delineated responsibilities.

As noted in the OIG's previous reports, Probation would benefit from more thorough and systematic reviews of its force incidents. Probation's Plan includes several promising use-of-force accountability improvements, including the creation of a Force Intervention Response Support Team (FIRST) and Probation Force Review Committee (DFRC) processes. These teams are meant to ensure that force incidents are properly reviewed, so that Probation is able to identify potential misconduct, and has the information it needs to recognize when its policies and practices need to be modified.

To fully realize the potential of these force-accountability improvements, Probation should ensure that the purpose of each team is clearly defined, and that respective responsibilities do not overlap. Probation should ensure that each team is properly and consistently staffed. For example, FIRST is tasked with operating Probation's planned Early Intervention System, which will be designed to track actual or potentially problematic employee behaviors. Accordingly, it should include team members with specialized education or professional backgrounds that are suited to the tasks of the team.

Recommendation 9: Probation should continue to improve its training efforts by effectively selecting its trainers and continuing to ensure that trainings are relevant.

Probation has identified and proposed increased training for staff in areas related to force, including de-escalation. As discussed above, Probation makes use of its staff as trainers. To ensure consistency and quality in its training program, Probation should develop and implement a rigorous, means-tested selection process in identifying training staff. Special emphasis should be placed on proven success in the subject matter at issue (*e.g.* staff selected to teach de-escalation trainings should have a history of successful attempts, etc.), and staff evaluations of said trainings should be routinely reviewed to determine quality of trainings. Trainers should also be required to refresh their training on a consistent basis, to ensure that their techniques reflect updated generally accepted practices.

Recommendation 10: Probation should ensure that its new use-of-force policy is clear, and provides necessary definitions for complicated concepts.

Probation is currently working to update its core use-of-force policy to reflect its planned elimination of OC spray and to provide greater clarity to its personnel. Probation should continue to work to create a policy that is relevant to the reality of

its operations, and that provides sufficient guidance to line-staff facing difficult and ever-changing situations.

The use-of-force draft policy reviewed by the OIG still includes central concepts that are not sufficiently clear. For example, the current proposed policy categorizes force as either "directed" or "immediate," which trigger different considerations and restrictions on the use-of-force by staff. "Directed" force is any incident during which a supervisor directs staff to use force. "Immediate" use-of-force includes force used to respond to an "imminent threat to facility security or the safety of persons," "Facility security" is not defined, despite the fact that the concept can include a wide-array of youth behaviors. A failure to define this threshold standard inappropriately shifts discretion to staff. For example, one staff member may consider a non-threatening act of disobedience, like a youth's refusal to return to their room, as compromising facility security, while another may not. This inconsistency will likely create confusion among staff, and may ultimately contribute to uses-of-force that erode trust between staff and youth.

The draft policy also contains provisions that appear to be in tension with one another. For example, the draft states that "obstinance" is not, on its own, a youth behavior that justifies force. However, the policy also lists the following behaviors as justifying the use-of-force: failure to follow instructions/disruptive behavior, refusing to exit area, and non-responsive to instruction. All of these factors can be plainly read as constituting obstinate behavior that does not include a threat of harm or assault, which increases the likelihood that staff may use force inappropriately.

Recommendation 11: Probation should improve its grievance system and strengthen its internal investigative system.

As discussed previously, this report back did not include a mandate for OIG to prove or disprove claims made by youth. However, the current levels of internal investigative staffing appear insufficient to properly handle allegations and many youth and staff are clearly not confident in the system currently deployed. As part of the Board's reinvisioning of civilian oversight of Probation, the OIG recommends that internal supervisory and oversight mechanisms be improved as well, including a strengthening of internal investigative capacity as well as strengthening the ability of Probation to evaluate itself in a data driven manner similar to the capacity available in the Sheriff's Department's Audits and Accountability Bureau. Such capacity is not, of course, a substitute for effective external oversight.

Conclusion

The information and recommendations provided in this report are intended to inform both the Board and Probation of issues related to the use-of-force within the County's juvenile justice facilities.